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NATIONAL INSTITUTE OF MENTAL HEALTH
TECHNICAL ASSISTANCE PROJECT REPORT

# MENTAL RETARDATION:

## Needs and Resources in North Carolina

## 1961

NORTH CAROLINA STATE BOARD OF HEALTH
NORTH CAROLINA HOSPITALS BOARD OF CONTROL
SCHOOL OF MEDICINE, UNIVERSITY OF NORTH CAROLINA

TECHNICAL ASSISTANCE PROJECT REPORT*

# MENTAL RETARDATION: NEEDS AND RESOURCES IN NORTH CAROLINA

May 23-25, 1961

N. C. Memorial Hospital
Chapel Hill, North Carolina

Sponsored by
North Carolina State Board of Health
North Carolina Hospitals Board of Control
School of Medicine
University of North Carolina

Participants: Forty representatives from professional groups and state agencies responsible for the mentally retarded.

Purpose: Examine and evaluate needs and resources in North Carolina with special emphasis on the education of professional groups in problems related to mental retardation.

*Technical Assistance Project for Conference on Mental Retardation, Grant No. SA-43-ph-4373, National Institute of Mental Health, National Institutes of Health, Public Health Service.

# PREFACE

Need for responsible action toward the care of the mentally retarded has become more recognized recently. Concern about this from local and state levels gave impetus to the development of a workshop conference to examine the needs and resources for the mentally retarded in North Carolina.

The North Carolina State Board of Health, North Carolina Hospitals Board of Control, and the University of North Carolina School of Medicine jointly sponsored this conference, which was held in Chapel Hill. Planning and organizational help was given by the regional office of the community services branch of the National Institute of Mental Health. Financial support was made possible through a Technical Assistance Project Grant, No. SA-43-ph-4373, from the National Institute of Mental Health.

Approximately forty participants were invited with 14 resource and faculty participants.

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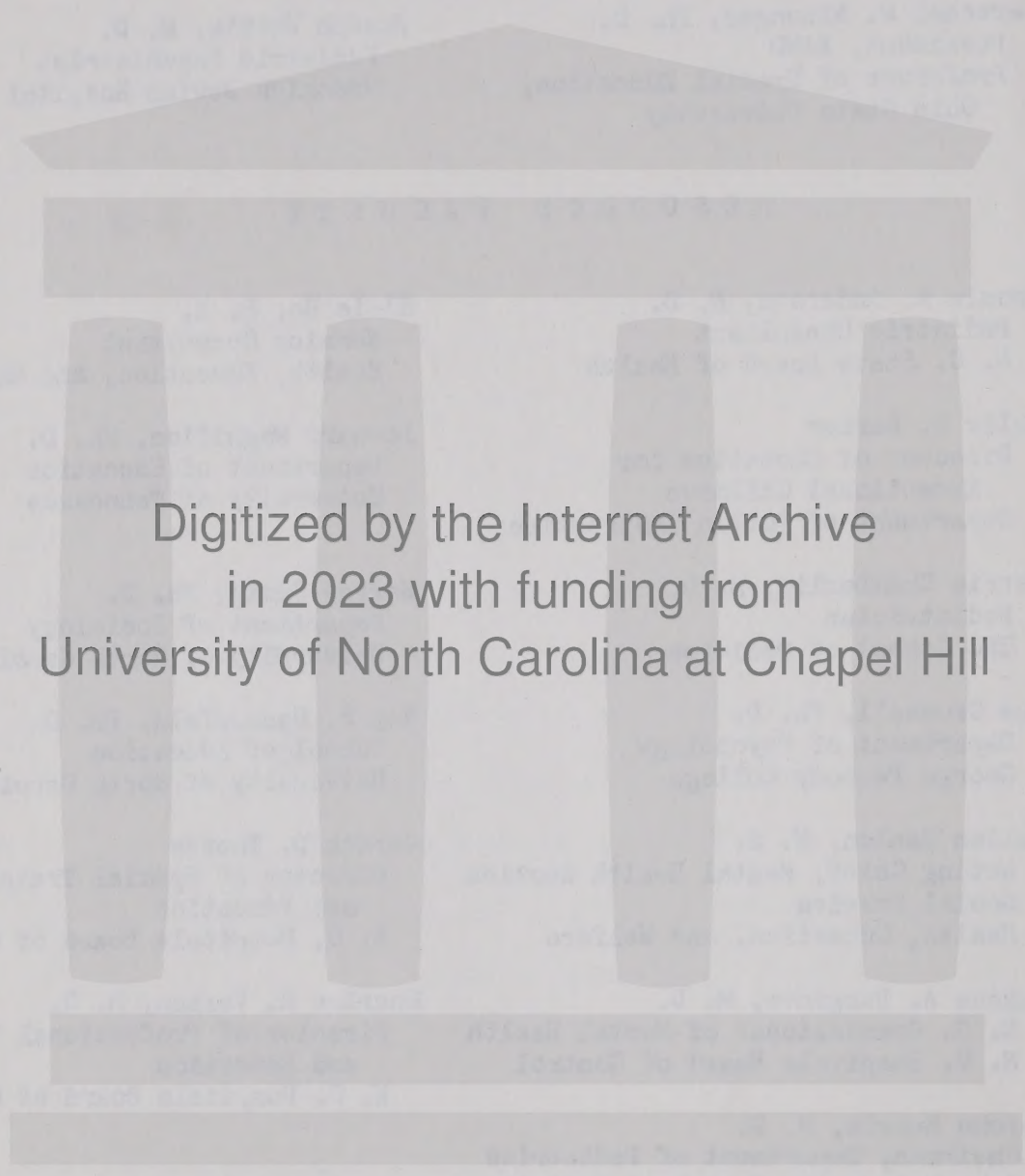

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# P R O G R A M

Clinic Auditorium, N. C. Memorial Hospital
Tuesday, May 23, 1961

8:00 p.m. - Address: "Mental Retardation: Social and Psychologic Implications."
Joseph Wortis, M. D.

**********

Gravely Auditorium
Wednesday, May 24, 1961

8:00 - 9:00 a.m. - Registration

9:00 a.m. - Medical Resources in North Carolina
N. C. State Board of Health
Ursula Anderson, M. D.
N. C. Hospitals Board of Control
Eugene A. Hargrove, M. D.

10:30 a.m. - Response and Discussion
Joseph Wortis, M. D.

.....

2:00 p.m. - Educational Resources in North Carolina
"The Current Scene in Special Education"
Herschel W. Nisonger, Ph. D.
Public Schools
Felix S. Barker
Institutions for Mentally Retarded
Gareth D. Thorne

3:30 p.m. - Response and Discussion
Herschel W. Nisonger, Ph. D.

5:00 p.m. - Reception - Schraffts' Country Inn

**********

Thursday, May 25, 1961

9:00 a.m. - Education of Professional Groups in Mental Retardation

Panel: Jerome Harris, M. D.
Charles R. Vernon, M. D.
Elsie Ho, R. N.

Moderator: Harrie Chamberlin, M. D.

.....

2:00 p.m. - Education of Professional Groups in Mental Retardation

Panel: Rue Cromwell, Ph. D.
Julian Hanlon, M. S.
Leonard Magnifico, Ph. D.*
Roy E. Sommerfeld, Ph. D.

Moderator: Harvey Smith, Ph. D.

3:30 p.m. - Summary: Eugene A. Hargrove, M. D.

*Doctor Leonard Magnifico was unavoidably detained by travel difficulties. Doctor Roy E. Sommerfeld kindly agreed to take Doctor Magnifico's place on the panel and discuss some of the problems in special education for teachers at the School of Education at the University of North Carolina.

## A C K N O W L E D G M E N T

Grateful acknowledgment is accorded to Mrs. Peggy Phelps, for her expert planning and arranging details of the program; Mrs. Ruth Wilson, for her untiring efforts in editing; Miss Frances Cleary, for social arrangements; Mr. W. W. Jarvis, for technical consultative assistance; Mr. Ossie Hatley, for his technical assistance; and Gravely Sanatorium for the use of the auditorium.

# INTRODUCTION

There was enthusiastic and immediate response from the selected participants for the conference. Representation was from virtually all state agencies and other professional groups responsible for mentally retarded people. These included pediatrics, psychiatry, nursing, social service, education, recreation and vocational rehabilitation, occupational therapy, and from state agencies representing health, welfare, education, and vocational rehabilitation. There was also representation from parent organizations.

A few out-of-state participants were invited from the SE region.

Throughout the conference individual session attendance averaged about 48. The spirit of every session was most gratifying. Interest and group involvement with active interchanges of ideas was notable. Concrete proposals were introduced and progressive plans discussed at length. As usual in meetings of this sort, the coffee breaks and other socializing expanded the programmed discussions.

The intangible but real spirit was most notable, although information and idea exchange were important. Only the latter can be revealed in this report.

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8:00 p.m. Tuesday -- The conference was initiated by the Tuesday evening program open to all interested persons, professional and lay. After a brief introduction by Doctor Vernon, Doctor Wortis presented an address entitled "Mental Retardation: Social and Psychologic Implications."

Doctor Wortis was invited to this conference because of his broad clinical experience in the field of mental retardation. His background in medicine, neuropsychiatry, child psychiatry, and finally mental retardation eminently qualify him to help us in North Carolina to examine ourselves in this area. He has headed up a comprehensive evaluation clinic for mental retarded cases at the Brooklyn Jewish Hospital and thus has come to know first hand of the basic psycho-social aspects of the problem as well as the biologic. His experience as a clinician combined with his wisdom as a farsighted citizen make him especially suited to the task of assessing with us the needs and resources in North Carolina for our mentally retarded.

Doctor Wortis presented a comprehensive clinical view of mental retardation. An abstract of his address follows:

# MENTAL RETARDATION: SOCIAL AND PSYCHOLOGIC IMPLICATIONS

by

Joseph Wortis, M. D.

Accurate diagnosis implies patho-physiologic and psycho-social understanding, and a rehabilitation appraisal. There is especial need for a realistic approach based on rehabilitation goals. Diagnosis includes every conceivable point of view including assessment of the family and community resources.

Mental retardation may be viewed as a chronic disease and clinical evaluation demands more than simply an esoteric pathologic diagnosis. Because most handicapped children fall in the 50-75 I. Q. bracket, the prognosis for rehabilitation is good. They have the potential presumably to learn to get along in the community if they get help and guidance and are provided with opportunities. The severely retarded will need more complete care throughout all their lives, but the majority of the less severely handicapped should be absorbed by special community medical, school, job, and social provisions.

Adequate help means statewide planning. A statewide plan should encompass all services retarded children will need for maximum development: clinics; special educational facilities within the public school system as well as in special institutions; vocational training provisions; occupational and recreational centers; job placement programs; and specialized work settings (e.g., sheltered workshops). Residential centers are for severe problems which cannot be accommodated locally;

the severity of the social problem rather than the severity of the retardation more often determines placement in the institutions. Severe medical and neurologic cases will always need special facilities probably best provided in residential centers.

Emphasis should be on day care and rehabilitation with graduated levels of care so that maximum individual potential can be exploited with minimum custodianship.

**********

There was enthusiastic response to Doctor Wortis' address in a brief discussion period; however, points of discussion were more thoroughly covered during later sessions so are not included here.

9:00 a.m. Wednesday -- The workshop itself began Wednesday morning. Presentations were made describing clinical facilities in North Carolina primarily from the medical standpoint. Doctor Anderson, Pediatric Consultant to the State Board of Health, was invited to present to the workshop her viewpoint of the problem. Intimately involved in implementing community plans for clinics providing evaluations for handicapped children, she has gained much knowledge of the situation in this state and formulated logical ideas for the future.

The residential centers for the mentally retarded in North Carolina are called schools. These institutions are within the purview of the North Carolina Hospitals Board of Control and the Commissioner of Mental Health, Doctor Hargrove. Doctor Hargrove was therefore asked to provide us with a picture of these institutions as they are and perhaps as they should be.

# NEEDS AND RESOURCES FOR THE MENTALLY RETARDED IN NORTH CAROLINA

by

Ursula M. Anderson, M. D.

I have been asked to speak to you today on the role of the State Board of Health in the field of mental retardation. I would like to express my gratitude to Doctor Vernon for his welcome invitation and also to the Medical School of the University of North Carolina, the N. C. Hospitals Board of Control, the N. C. State Board of Health, and the National Institute of Mental Health, who have made this workshop possible.

I have elected to take as the subject of my paper the title of this workshop, "Needs and Resources for the Mentally Retarded in North Carolina." To do justice to the subject allotted to me and in order to give lucidity and logicity to what I am about to say, it will be necessary to make mention of the multifarious factors involved in the diagnosis and management of the retarded child.

Management implies the need for services and before we can logically plan our services we need to have a clear idea of the needs we intend to plan for. To do this constructively, we must first look over our shoulders to the past, take stock of our present status, and then project ourselves positively into the future. Furthermore, as mental retardation is often accompanied by other handicaps as well, it behooves me to treat of this subject as a multi-faceted entity and not as a single entity as so many of us are in the habit of doing.

As many of you know, I am a pediatrician. What I am about to say will be said not only in the light of the role the pediatrician plays in the diagnosis and management of the retarded child, but also with the deep conviction that the total management of these children is something no one discipline can or should shoulder alone, but that it involves the cooperation of many disciplines, psychologists, educators, social workers, as well as pediatricians and other members of the medical profession. However, as I proceed, I will highlight the role of the pediatrician, as I see it, against the total background of the many factors involved; and I will treat of the role of the State Board of Health in providing resources to meet the needs of which I will speak.

In order to illustrate what our thinking has been in the past, let me briefly turn your attention to a composite classification of the larger groups of handicapped children.

There are six large groups of handicapped children.

1. The physically handicapped.
2. The emotionally handicapped.
3. The mentally retarded.
4. The mentally sick.
5. The socially maladjusted.
6. Those with specific problems; e.g., conceptual and perceptual.

We have become used to thinking of children as belonging to just one of these diagnostic groups and rarely have we allowed sufficient elasticity of mind to allow the concept of an individual child belonging to more than one of these groups. To illustrate my point, let us turn briefly to the physically handicapped group of children. For those of you who like the neatness of classification - indeed at times I do myself - I have tried to classify the larger groups of physically handicapping conditions.

1. Cerebral palsy.
2. Epilepsy.
3. The blind and partially sighted.
4. The deaf and partially deaf.
5. Cleft lip and cleft palate.
6. Speech defects.
7. Rheumatic fever and its sequelae, and congenital heart disease.
8. Orthopedic defects.
9. Delicate children.
10. Children with chronic disease. For example, renal disease, diabetes, cystic fibrosis, etc.

At a glance, one can see how artificial this classification is. To illustrate my point, a child with a cleft palate always has a speech defect, and although his primary handicap is his cleft palate, his indistinct speech is just as great a handicap to him, and if unattended will also give rise to emotional problems which affect his learning ability. Similarly, a child with cerebral palsy may also have epilepsy, orthopedic defects, and furthermore he may be mentally retarded. I hope this will serve to emphasize the fact that a handicap occurs but rarely in isolation, and that while a physical disability may initially predominate the picture, the emotional, psychological, and social constituents of the child's total environment become inexorably interwoven into the pattern of his problem. I will return again to this theme for the simple reason that one cannot logically plan the management of a child unless one considers him in the light of his totality.

In the past, our services have been geared to the kind of thinking I have indicated; namely, that we tended to pigeonhole our handicapped children into one or the other of our large groups and plan services for them accordingly. For example, a child with a physical handicap was treated as though he only had a physical handicap, and rarely did we allow ourselves to imagine that he might also be retarded. The

certification of teachers for the physically handicapped child demonstrated our thinking in this matter. In 1959, few, if any, states had certification requirements which necessitated the teacher of the physically handicapped to be also trained in the needs of the retarded child, in fact most physically handicapped programs in the past admitted only children who were of normal intelligence. However, comparison of four reports of the diagnostic classification of crippled children by Fenton and Connor reveal that the incidence of crippling from infectious diseases had decreased from 54.88% in 1929 to 8% in 1958. In 1929, the vast majority of these children were crippled with the residuae of osteomyelitis, while in 1959, all of the children were crippled as a result of polio, osteomyelitis, of course, being all but eliminated with the advent of the antibiotic era. In the same period of time the number of children with physical crippling as a result of cerebral palsy had risen from 17.7% to 45%, and 70% of these children have below normal intelligence.

Now I would like to direct your attention to the child with mental retardation. In order to create a concrete premis from which to proceed, let me clarify by definition as best I can what it is we imply when we say mental retardation. To answer this question, let us first turn our thought to the quantity we, by inference, are measuring, namely, intelligence. Intelligence is a quantity difficult of definition. It is a composite of many different faculties, for example, the ability to think abstractly, visual and auditory memory, causal reasoning, perception, the faculty of concept, spatial comprehension, verbal expressions, and probably many other factors. Determining a child's intelligence then is much more of a monumental job than many of us at first imagine and

the import of the label we place upon the child is tremendous. However, from an analysis of the factors involved we can derive a definition of a retarded child as one with inadequate cerebral function in any or all of the above faculties which affects his ability to learn or behave in the manner we would expect when compared with his peers, or that nebulous quantity we call the average.

In the past what have we done with our retarded children? We have become addicted to the habit of thinking of a retarded child as one with an I. Q. below 75 and furthermore for our own convenience have divided them into three groups.

1. The educable group, with I. Q.'s ranging between 50 and 75.
2. The trainable group, with I. Q.'s ranging between 20 and 50.
3. The custodial group, with I. Q.'s of less than 20.

This classification has taken on the characteristics of a three-track railway line, all three groups pursuing parallel courses with no chance of side-sweeping, let alone a meeting of the paths. This approach is fraught with not a little fallacy. Because of the nebulous quality of the quantity we are measuring, the experimental era that is bound to occur due to the interplay of many factors, not least of which is the human inability to be totally objective in evaluation, and also the fact that many of these children have physical and other defects, the cause of which I will discuss later, all these factors affect their management. As a result, we run into cases where a child is placed in a trainable group when, indeed, he would be better placed in the educable group and vice versa. We cannot regard the retarded child in terms of a number, but we must see him against the backcloth of what he as an individual

can do. It would also seem pertinent to say at this point that the general prevailing philosophy was to institutionalize the child.

Furthermore, if we ponder what I have just said, we see that we have laid emphasis on the school age handicapped child and exposed the fact that we have left the handicapped infant and preschool child in the outer fringes of our thinking.

Turning now to take stock of our present status, we are in for many surprises when we analyze the changes that are taking place. The total child population is increasing so that the number of handicapped children may also be expected to increase. Modern medical care is saving the lives of more premature babies and of infants and children with acute and chronic illnesses than ever before and many of those saved may be left with a residual or potentially handicapping defect. Modern medical care may then in paradox be contributing to a disproportionate rise in the number of handicapped and retarded children. Furthermore, research in genetics, biophysics, and biochemistry are revealing to us the causes of many syndromal patterns. When the cause of a child's handicap and his mental retardation has been pursued to the point of his cellular metabolism and chromosomal pattern, one readily sees the totality of his dilemma and exposes the fact that we can no longer logically think of our handicapped and retarded children in terms of a single handicap. This latter fact can be readily appreciated if we look for a moment at a brief and simple classification of the aetiologic factors operating in these cases.

Time does not allow of a lengthy classification of the aetiologic factors involved, indeed not all of these factors are known, but to

highlight what I have already said and what I am about to say, the following brief classification will suffice. We can conveniently divide these factors into those operating in:

1. The ante-natal period.
2. The para-natal period.
3. The post-natal period.

The factors operating in the ante-natal group indicate those genetically determined as well as those due to maternal illness during pregnancy. The para-natal group include those cases due to birth injury, which in itself may result from many different factors involved in labor. The post-natal group includes all factors involving the child himself after birth, e.g., infections and injury.

If we dovetail the changing face of pediatrics with the brief aetiological classification I have given, we see thrust upon us a whole new sphere of responsibility in the area of prevention; and this responsibility lies primarily with the pediatrician. Furthermore, it should guard us against the pitfall of regarding mental retardation as a single clinical entity and should alert us to the fact that it is commonly associated with recognizable changes in the central nervous system, the cardiovascular system, and other systems of the body.

Simultaneously, our thoughts are turned from the services geared to the salvage of the already handicapped child to the aspect of true prevention, where we can prevent the development of permanent injury in a child who has a potentially handicapped defect.

Although at present we know the metabolic errors responsible for some of these syndromal patterns, there are but a few for which we have a diagnostic test and subsequent preventive measures. It is, however,

the pediatrician's responsibility to screen all children under their care, whenever practicable, in order to eliminate the possibility of them having these defects. Such conditions would include phenylketonuria, galactosemia, etc. These are two instances of cases where children are born with normal potential but have a defect, the disastrous effects of which if detected early enough can be prevented.

The care of the newborn and premature infant is also of vital importance in the sphere of prevention, but this is subject matter for a paper itself and so I can but only mention it.

Prevention is of concern to the pediatrician not only in the primary preventive sense as applied to the detection of a defect before it has a chance to produce its effects, but also in the secondary preventive sense, in which a defect or handicap is already present. In this context, early diagnosis is essential in order to mitigate the effects of the defect, and to set in motion the orchestration of the other services necessary for the total evaluation and planned management of the child.

As a pediatrician sees it, the following factors are essential to total diagnosis.

1. Family history.
2. History of pregnancy, delivery, and neonatal period.
3. Evaluation of the motor, social, and adaptive development of the child.
4. Physical examination.
5. Neurological examination.
6. Laboratory tests.
7. Psychologic and educational evaluation.
8. Speech and hearing evaluation.
9. Social evaluation.

This procedure should be followed in all children who are handicapped or potentially so, and it emphasizes again how the pediatrician

is totally comprehensive in his approach to the child. As to how this total evaluation can be achieved, I will treat of later.

During the first year of life an infant can be expected to follow a fairly standard developmental pattern. He may deviate from this expected pattern for many reasons, but the earlier a deviation and potential handicap is detected, the sooner treatment can be instituted. A pediatrician in his normal follow-up of a child usually anticipates any possible deviation by assessing the child's developmental pattern against that of the average. I would like to emphasize the vast importance of this type of early detection by taking the example of the deaf child. An infant who is deaf should have his defect detected no later than the seventh or eighth month for the simple reason that some eminent people believe that if a child is denied the stimuli necessary for the establishment of normal speech later than the fifteenth month, that child will never have perfectly normal speech. If this is so, and from my own observations, I believe it is then you see the tremendous responsibility the pediatrician has to actually go looking for possible defects. Now, deafness may occur alone or in association with other congenital abnormalities. The child born to a mother who has had German measles during her pregnancy may be born with brain damage, mental retardation, congenital heart disease, and deafness. On the other hand, a child may be born with deafness as his only initial handicap. In either case, if the deafness is not detected early, we are allowing the superimposition of the consequent speech defect and in the case of the child with normal intelligence, a learning disability and possible emotional disturbance, and in the case of the retarded child an aggravation of these factors.

This says nothing of what this kind of situation means to the parents. Personally, I would like to see the need for deaf schools not only halved, but quartered over the next few years as a result of this early detection.

So far, I have laid great stress on the need for prevention not only because this is my particular field, but because this should be our aim in every instance where it is possible.

In the light of these changes, we must keep our minds and plans dynamically adjustable to the changing needs. Having thus arrived at the present, let us turn to the future and give thought to the positive action needed to program services for the retarded handicapped child in the light of this changing pattern.

As a pediatrician, I fervently believe that the rightful place for all children is within their own home and their own community. As a general rule I believe that all children should be kept in as near normal an environment as possible within the limits of their handicap. I believe that their management should never be a static thing, but infinitely adjustable to the needs of the child; and this necessitates periodic evaluation of the child's status and progress. This is the philosophy on which I have based that part of my paper which deals with the future.

So far, we have considered only the child, but all children belong to parents, families, communities, and society in general, and all of these people are, and should be, vitally concerned in the welfare of the child. This being so, they must, of necessity, be included in the management of the child, and I pay no lip service to the need for the

inclusion of all people concerned with the child in the structuring of our programs. Having established the child as a part of society, we must think of him also in the light of his total life span, for he belongs to society during all of his life and not just in fractured parts of it. This kind of thinking becomes increasingly more important in the light of my remarks concerning the changing face of pediatrics and the need for early diagnosis and prevention. The object of prevention is control of the causative factors of disease, and this being so, we need to structure our community services on broad and specific bases. Seeing the child in the light of his total life span, and recognizing the need for primary prevention, the community maternal and child health services become of vital importance. Adequate prenatal and obstetric care should be available to all women to prevent, as far as possible, the complications of pregnancy which might endanger the development of the fetus, result in prematurity, or cause a handicapping condition in the newborn. Ideally, this service should be available through the private physicians, but where this is not possible it becomes the responsibility of the state and local health agencies in cooperation with the physicians to provide this service. These services should not only provide medical and obstetrical care, but should be geared also to a general process of health education, and this is particularly necessary in the lower socio-economic groups. Following birth, the need for the application of good prevention becomes almost mandatory. This is primarily a responsibility of the medical profession and can be accomplished by the provision of facilities for the expert examination of all infants and their regular evaluation during their first year of

life and their continued health supervision during childhood. The earlier a handicap or a potentially handicapping condition is detected, the more chance we have of preventing disabling affects. Again, where possible, this type of service should be provided by the private physician, but where this is not possible it becomes the responsibility of the state and local health departments to provide these services, which should be constructed in harmonious cooperation with the local physicians and not in competition. When structured in local health departments, these clinics should have a pediatrician in charge, and the necessity for close cooperation with the health director, the public health nurse, and other interested agencies is obvious. Such broad preventive measures could be usefully applied in the so called "well baby clinics" conducted in our local health departments, and indeed such is the philosophy we are trying to establish in North Carolina. To this end also we have advised a statewide program of screening all children in the first four months of life for phenylketonuria. Implicit in this need for prevention is the necessity to make those responsible for the care of the mother and the child aware of the preventable causes of disease and the measures that can be taken to avoid them. This responsibility lies primarily with the physician, and thus more emphasis must be given in the future to the education of the medical student and the training of the pediatrician to the aspects of growth and development and preventive pediatrics. Refresher courses for practicing physicians, both pediatricians and general practitioners, are also indicated.

Allied to this type of broad preventive care, we need specialized clinics for the diagnostic evaluation of the child found to be retarded or handicapped, or potentially so. These clinics may be located in:

1. Hospital and medical center out-patient departments.
2. Out-patient clinics in small communities.
3. Local health centers where they may be administered by official or voluntary agencies.

Most of the handicaps a child may have require more than the doctor-patient relationship for their complete evaluation and management, and particularly is this so for the retarded child, who as I have already indicated is more likely than not to be multiply handicapped. As the child grows he and his family increasingly need the services of social workers, psychologists, nurses, and educators; thus these specialized clinics should be staffed by members of all these disciplines. The function of these clinics is to provide not only diagnosis and evaluation, but should include effective means of follow-up and also provide a constant source of planned care for the child and his family.

Such clinics are in keeping with the philosophy that when needed, services are offered to the retarded and handicapped living at home in the community; the cost to the taxpayer is small, the child is given the best opportunity and environment in which to develop, and very often the emotional stability of the family group may be preserved. When the work-up of such children is completed, the findings and impressions of the staff personnel are interpreted to the parents in a counseling session. At this point I would like to point out that there are in North Carolina five such clinics in operation. All five clinics are located in local health departments - Charlotte, Washington, Oxford,

Warrenton, and Morganton. These clinics are sponsored by the Maternal and Child Health Section of the State Board of Health. When further evaluation is required of a nature that requires referral to a hospital out-patient department, this also is effected. Because we advise keeping the child at home as often as this is possible, and as we see the child at least once a year, in the intervening time the public health nurse plays a vital role in counselling the family and as liaison between them and the clinic staff.

I service two of these clinics myself, and I am convinced of their great usefulness to the child, his family, the school authorities, and as an educational process for the clinic staff themselves. I would here like to mention that there has been and continues to be a great deal of liaison between these clinics and the education authorities. In one area alone after three clinic sessions, we were able to present the education authorities with a sufficient number of children for them to press their claim for the establishment of a class for special education in their area. While this is satisfying, we all realize that it is but skimming the surface of the vast problem that needs to be met, but at least we are making a beginning.

In addition to these clinics, during the fiscal years 1958-60, the Mental Health Section of the State Board of Health reported that 2,484 children were seen and 452 were given a diagnosis of mental deficiency. This was a frequent diagnosis (18%) for child patients, particularly for the very young. It accounted for one-third of the diagnoses reported for children under five years of age. The proportion remained comparatively high for children of school age and declined to less than 2% among adults.

Further tabulation indicates that in the process of providing this diagnostic service to each child, there is a total of at least three interviews with the patient, his parents or others such as social workers from welfare departments, public health nurses, school personnel, physicians, and ministers. The diagnostic services include not only the compilation of social, psychological, and psychiatric material, but most important provides the interpretation of the diagnosis to the parents or to the source of referral.

Having laid great stress on the fact that the rightful place for all children whenever possible is within their own home and their own community and recognizing that all children should be kept in as near a normal environment as possible, we are immediately faced with the problem of providing resources to meet the needs created by this kind of philosophy. In doing this we should bear in mind that not only is this a more humanitarian approach, but also it is much a cheaper one than institutionalization. Institutionalization is <u>not</u> the answer except for those children who really need custodial care and their number is small, smaller indeed by far than the numbers both in and on the waiting lists for our institutions would indicate.

I have already dealt with the great need for prevention and early diagnosis and for the need for special clinics where trained personnel can counsel the parents and plan the management of the child. Very often a child can be kept happily at home during his pre-school years, just on the basis of counseling from the clinic and the public health nurse who visits in the home. However, there are cases where benefit would accrue to the child and his family from the child's attendance

in a nursery school designed to accommodate like children. Indeed at times if the home environment is non-stimulating, the child may benefit from inclusion in a regular nursery class if his retardation and behavior allow of it.

In this context as in all other contexts relating to the retarded and handicapped child, state and local boards of health have a golder opportunity to show leadership in initiating and maintaining such facilities in cooperation with other state and local and volunteer agencies who would share responsibility and interest.

When we come to the school age child our needs are legion. We need more and more classes established for the education of retarded children. In North Carolina, happily it seems that the general philosophy is to include these classes within the framework of the regular school. This is as it should be. My friends following me this afternoon will be dealing with this subject, but before I leave it, I would like to say that the closest cooperation should be established at the state and local levels between the health and education authorities in the structuring of these programs. As I have already illustrated, the health authorities can be of immeasurable service in the initial phases by establishing diagnosis and indicating plans for management through the clinic services previously described, and we can give a real boost to their efforts in trying to establish the need for special classes. Furthermore, as many retarded children have other handicaps, the need for their continuous medical supervision is obvious and therefore also is the need for contimued cooperation between the health and education authorities. For those children who are too retarded for such educational

opportunities, some kind of occupation center where the child can attend daily and spend six to eight hours in a sheltered environment and be taught the fundamentals of self-help, sociability, etc., is indicated.

At this point, let me ask a pertinent question. To what end are we educating these children? At the present time it seems there is an abyss of nothingness once the child has left school, and little or no place for his inclusion in the community.

Thus it would seem that we need also to look beyond the school house gates to the time when he will become an adult and needs to be absorbed, as are his normal neighbors, in a useful manner in the service of his community of which he is an equal member. Nearly all, save the severely retarded, can be taught to do something if we take the trouble to find out where their potential lies.

To this end, we should orientate our school programs to fitting these children towards taking their place in the community and to fitting them for the job opportunities that best suit them. Again this is the domain of the people who will be speaking this afternoon, and so I will but mention it.

However, it can still be a duty of the state and local health agencies to provide a program of orientation to the problem of habilitating the retarded child in the community, and this orientation is directed at professional and lay groups. From my personal experience, I have found a great deal of interest shown by lay groups such as Rotary, Moose, etc., and these are the people who can provide the job opportunities for these children. There are some children who could be absorbed

admirably in a sheltered workshop environment.

In conclusion then I would say our needs are great, and our current resources small in comparison. If we will but broaden our horizons and see the child in the light of his total life span and be vigorous in our pursuit of the provision of facilities geared to keeping the child in his home and community, there is no doubt that in time we will realize resources to match our needs.

# INSTITUTIONAL RESOURCES AND MEDICAL RESPONSIBILITIES FOR THE MENTALLY RETARDED IN NORTH CAROLINA

by

Eugene A. Hargrove, M. D.

This morning I should like to discuss not only institutional resources for the mentally retarded in North Carolina but also medical responsibilities for the retarded in institutions as I see these. First, I shall briefly mention institutional facilities existing in the state, discuss the man power resources and needs, and the programs of care in our institutions for the retarded.

This review of facilities is old to all North Carolinians here; but for those of you out of state, I should mention that our present facilities include four institutions for the retarded. The oldest institution, Caswell, is at Kinston, North Carolina, and began operation in 1913. There are now approximately 2,000 there. O'Berry, at Goldsboro, North Carolina, opened in 1957 and is planned for 1,200 children. Murdoch, at Butner, North Carolina, began operation in December 1957 and will have approximately 1,600 children. The fourth school, being built in Morganton, North Carolina, will have 600 children initially. It is anticipated that eventually this unit will have 1,200 children. These facilities when complete will care for approximately 6,000 children in the state.

It is interesting to note that this program is relatively new in North Carolina; the last three institutions named have been in operation only since 1957 and the other institution, Caswell, provided only 900 beds until ten years ago when it expanded to its present capacity.

In addition to these facilities which the state provides, there is the new diagnostic unit at Murdoch School. We used Doctor Wortis' unit in Brooklyn as a model, and we hope that ours will grow to comparable stature.

Also at Murdoch is the psychotic children's unit. This again is a recent development. Eventually we hope all the institutions will have diagnostic units and units for emotionally disturbed and mentally sick children. We think it is rational and reasonable to have the several components concerning child development together in an attempt to provide the children with comprehensive, flexible, and integrated care.

As part of each child development center we plan to develop vocational rehabilitation units, as we have at Caswell. This unit, in existence only one year, has contributed substantially to our comprehensive care plan. You will be hearing more about this phase this afternoon from Mr. Thorne. This year the North Carolina Legislature appropriated money, to be matched with federal funds, which will be used to develop and expand our vocational rehabilitation facilities for the retarded children, not only within the institutions but in the communities utilizing rehabilitation houses and sheltered workshops. Additional resources for the retarded are found in the few small private institutions, licensed by the Department of Public Welfare, which provide care for approximately 200 children. This is a small number considering the overall need, but more of these are coming into existence. Some take care of 3 or 4 children; others are larger, such as Doctor Hinman's excellent facility at Winston Salem in connection with Bowman Gray.

So much for institutional resources! The man power resources in North Carolina, as in other parts of the country, are limited particularly in professional categories. I am gratified to see that the entire discussions tomorrow will deal with the training possibilities for professional people in mental retardation. In North Carolina we are fortunate to have intelligent, young, and vigorous leadership in our institutions; we find that more young people are becoming interested in mental retardation. Consequently, the caliber and training are better of the individuals coming to this field from medicine, pediatrics, psychiatry, social work, nursing, psychology.

Certainly with the man power shortage there is need for us to search for different approaches than we have at the present time in an attempt to maximize the potential of people who are already working in mental retardation. This means that we have to devise special uses of these people and special programs to train and retrain them, particularly as the institutions change from strictly custodial to rehabilitative programs. The cottage parents in North Carolina are for the most part stable, kindly, and well motivated. We are fortunate in having this very good large group to act as cottage parents and work directly with the children. Here again is a good resource, but one which needs further potentiation.

Special uses of personnel, as well as patients, have to be explored. For example, Doctor Rippy in the emotionally disturbed children's unit at Murdoch, has some of the older stable retarded children helping with some of the seriously mentally sick children. These retarded boys and girls have done an excellent job in their day-to-day care of the

emotionally sick child, and in some instances, this help has brought a change in the capacity of the mentally sick child to relate and grow emotionally.

Our programs of course are resources. I would like to discuss those which our institutions have and envision. These can be discussed from three facets, based on the traditional approach of medicine to any problem of maladaptation. We look at these programs in terms of care or treatment, training or teaching, and research or investigation.

The care or treatment responsibilities of the institutions are threefold: (1) the diagnostic process which Doctor Anderson has so excellently presented to us; (2) appropriate and adequate medical care while the child is in the institution; (3) adequate emotional care, which includes social and psychiatric approaches for the patient and his parents. Both Doctors Wortis and Anderson have pointed out to us the complicated process of a diagnosis and the need to be aware of the multiplicity of factors involved in mental retardation.

In agreement with our previous speakers, we also feel that the present-day, modern residential program should rehabilitate the individual, should assist him in achieving his potential in a social, emotional, and intellectual way, and should return him as early as possible to his home and community. It is no longer valid for us to consider the residential center as a permanent abode or segregation facility for these children. With this philosophy the institution has a responsibility to work with the community and when necessary to point out to the community some of the deficiencies which exist in it as seen from the institution's viewpoint. The institution has a responsibility

to criticize the community and its facilities just as the community has the institution. There are many times when the institution should ask the community, "We have a child who is ready to return; he no longer needs residential care. What can you provide for him in your community?" This is in line with some of the suggestions that Doctor Anderson has already detailed to us. I think we have to keep in mind that our residential centers must be therapeutic and goal oriented and not primarily custodial. The institution itself has a continuous job of re-diagnosis, re-evaluation of every child, as well as re-development of constructive treatment and rehabilitation programs.

The diagnostic process should include not only evaluation but plans for the most appropriate program to follow with the child and his parents. These plans may call for institutionalization, but more and more often, I hope they call for community disposition or placement. The diagnostic process should be a continuing one for those in the institution so that we may reassess their problems and when necessary change treatment and rehabilitation programs. The physician, of course, plays an important role in providing the diagnostic service, but we are continually impressed by the need for a multidisciplinary approach in this area. We saw a most effective operation of this at Doctor Wortis' clinic. There the pediatrician, neurologist, psychiatrist, social worker, nurse, psychologist, public health nurse, and educator worked together for the most appropriate and unique program for the child.

The diagnostic process should include work with parents around disposition whether institutionalization or otherwise. Doctor Wortis mentioned last night that in his clinic they considered and discussed

at great length the need to work with parents around anxiety, guilt, and ambivalent feelings, but that in most instances, they ended up working mainly with the child as a handicapped child. The staff itself accepted the retarded child openly and realistically; this attitude seemed to go a long way in allaying the anxiety and the guilt of many of the parents. This means the attitude and the orientation of the staff itself is highly important in the diagnostic and planning process.

Within the institution the medical responsibilities of course continue. In our institutions in North Carolina we believe it is no longer appropriate to provide just a general practice type of medical care to the children and to ignore the basic medical, social, emotional, and psychiatric problems which have brought these children to the hospital in the first place. The institutionalization of a child when necessary should enhance his development and not lead to further social crippling.

There is, of course, the problem of dealing with the emotional health and social deficits of children in the institutions. We are aware that many of these children are not well equipped to meet all of the demands which may be placed upon them in regular society, but we are also aware that the institution itself may increase these emotional and social deficits and lead to emotional stunting. It is true that the institution, with its group functions and processes, has certain assets for the child which should be capitalized upon. One way to minimize social crippling is to make the institutionalization as short-term a process as possible for as many children as possible.

Many of my colleagues in psychiatry shun psychiatric treatment or psychotherapy for the mentally retarded; many, without actual experience, believe psychotherapy for the retarded is unrewarding and unproductive. Stacy and DeMartino in their book on Counseling and Psychotherapy with the Mentally Retarded have shown that this is by no means true--that many of these children have emotional conflicts, which respond to psychotherapy; and sometimes the treatment is simpler and more effective than dealing with the normal or gifted child.

Whenever a psychiatrist works for a while in an institution for the retarded, he is forcibly struck by the need for the application of psychiatric principles to the whole patient population--from the severely retarded to the mildly retarded. In most institutions that I know about, including our own (although this is changing), unimaginative custodial care is utilized with the severely retarded child. We note that this breeds further problems and leads, in many instances, to further regression on the part of the child and to problems in management which demoralizes the staff as well as the child.

Shortage of personnel is of course a part of the problem, but utilization of personnel to the best advantage is frequently lacking.

We find, too, that the group of mildly retarded in our institutions are almost without exception in need of psychiatric evaluation and social management. Modern psychiatry emphasizes the ecologic approach, i.e., the need to understand the organism in relationship to its environment. The psychiatrist can apply this principle in developing an overall program for the institution as well as in individual assessment and

treatment. We find, too, that psychiatrists in the institution discover more and more children who have disabilities other than retardation, and who need other approaches to their particular problem.

The second aspect of an institution's program is that of in-service training. Doctor Charles Vernon, who is our Director of Professional Training and Education for the state hospital system, has inaugurated a series of in-service training programs for our hospitals and institutions in which physicians, nurses, social workers, psychologists, educators, and others can participate. We all need stimulation of new ideas from time to time; we need our attention drawn to new techniques, new processes, new ways of evaluation, new approaches to care and treatment and to the research possibilities that exist. These training programs have a place in stimulating and training personnel who are on the job today caring for the children.

Physicians, particularly in those institutions located near universities, often participate in training and teaching medical students and residents in psychiatry and pediatrics. In my opinion, there is too little emphasis placed on mental deficiency in our medical education programs, and I am sure the panel tomorrow will address itself to this problem and to some of the possible solutions.

Although postgraduate training programs and medical curricula are filled, and even crammed to the brim, I believe specific instruction will do more than just give information about mental retardation; it will more importantly demonstrate the optimism concerning rehabilitation potential and the possibilities for prevention of mental retardation.

The third aspect of a program in an institution has to do with research, which has been conspicuously lacking in the field of mental retardation. Doctor Myron Sandifer, Director of Research for the state hospital system, as part of his work, encourages, stimulates, and works with others in mental retardation research. Many of the problems are complex and need a multidisciplinary approach with a whole gamut of professional people involved. To my knowledge there are no well-controlled studies which have been done to determine the results of the application of intense, dynamic psychiatric principles to a total push program for a group of institutionalized retarded children, particularly when the program is based on modern sociologic concepts.

Sometimes in the institutions, unfortunately, an individual develops a psychotic reaction under our very eyes. Here is an excellent laboratory in which to test some of our current hypotheses in regard to the development of psychosis: the role of interpersonal relationships, epidemiologic aspects, the role of biochemical or metabolic processes, etc.

There is one resource which I would like to mention which is a resource for those who work in the field of mental retardation. These are the universities in North Carolina and, particularly, the professional schools in these universities. Every effort should be made to bridge the gap between programs in professional education and research in universities and programs of service in hospitals, clinics, and other agencies. It is essential for academic institutions to know more about problems of service agencies and for the latter to have the benefit of the thinking and knowledge of universities. Continual cross

fertilization between the two, we believe, will result in more appropriate emphasis on mental retardation in the university curricula. The service institutions, by opening their facilities to the faculties of the universities, will allow these faculties to make a more realistic assessment of social needs which would in turn influence educational program planning.

Many of you know about the liaison which exists between service institutions and professional schools and departments in the universities. The Pediatrics Department at Duke University worked with us from the beginning at Murdoch School and have given us considerable support, not only moral but actual man power help. This relationship has grown and is increasingly fruitful in establishing training and research programs.

The University of North Carolina School of Social Work has used our institutions for field assignments. They have helped with our in-service training programs and have been on the lookout for likely staff placements.

The University of North Carolina School of Nursing has given us considerable help with our in-service training programs and have been willing consultants to our nursing problems.

Both the Department of Pediatrics and Psychiatry at the University of North Carolina School of Medicine use our facilities in training medical students and residents. The Department of Psychiatry has provided refresher courses for many of our staff physicians. The Social Science Research Section of the Division of Health Affairs, under Doctor Harvey Smith, has been a tremendous help to us in evaluating

some of the many social problems which exist and in helping to interest and train individuals in the sociology of this particular area.

The resources and the responsibilities for the mentally retarded in North Carolina are changing. The institutions need to be used much more flexibly. We must look at the institution as just one facility of many, and, if needed, as a transitional phase in the child's total development. Reliance on the institution is not a substitute in any way for community planning.

As our concepts change and as we add information, the aims, the programs, and the facilities in these institutions should continue to change as we meet our responsibilities in this area.

# RESPONSE TO DOCTORS ANDERSON'S AND HARGROVE'S PRESENTATION

by

Joseph Wortis, M. D.

Doctor Vernon has suggested that we use the remaining time this morning for some back and forth discussion, questions or comments and has asked that I start the ball rolling by making some introductory comments. Puddin' Head Wilson once said, "Be right and you'll be lonesome." I often thought that was just the opposite of the truth and that if you figure out anything right, you would find a lot of people thinking the way you do. So it is a real pleasure to travel hundreds of miles after pondering on the questions of mental retardation and community services to find that people down here think exactly as we do up in the frozen north. I find nothing at all, not one word, to change or to disagree with in the things that have been said so well this morning. I can only congratulate North Carolina on having people who can think so clearly and so far, and who seem so well equipped to do a good job in this field.

It was particularly nice to hear the broad perspectives outlined by Doctor Anderson in a British accent, because I am something of an Anglophile and particularly an Anglophile in the field of mental retardation, because Britain, I think, by common consent stands ahead of all countries in their planning and provision of services for the retarded. Holland may be a close second. The Scandinavian countries are doing pretty well, but England is foremost in the development of advanced thinking and advanced planning in this field.

Doctor Anderson touched on a great variety of topics. I will only comment briefly on them in more or less helter-skelter style. As a pediatrician, she emphasized particularly the role of the pediatrician. I am a psychiatrist; my clinic happens to be set within a pediatrics department. Our medical staff is half and half psychiatric and pediatric. I think there can and should be no quarrel about the distinctive role of a pediatrician and the psychiatrist in mental retardation work. Both are needed; both have an important contribution to make, and I think the differences emerge not so much in the assignment or assumption of duties as in the skills, the points of view, and the perspectives they bring to the work. We find our pediatricians are particularly skillful in dealing with the younger children, because of their long experience with this age group. We psychiatrists have relatively little opportunity to work with the younger child, while the pediatrician is at home in this field. Certainly, the pediatrician is better equipped than the average psychiatrist in dealing with the many medical problems involved in this area, and he brings to the rehabilitative work a down-to-earth, practical style of approach, which is a good balance for some of the refinements of psychodynamics that we psychiatrists are likely to bring into this area.

One common concern, of course, that we share with the pediatrician is the broad area of preventive work in the field of mental retardation. Doctor Anderson singled out for special emphasis the problem of prematurity. I quite agree that prematurity and mental retardation have very important interrelationships: We are running a big IBM punch card analysis of our case material, and one of the first things I did when

we had our cards punched was to run all the cards through of children with I. Q.'s below 50 and separate them from all the other children in our clinic. (We are a psychiatric service, by the way; we have a number of non-retarded children, too.) I then ran all the cards through to sort the children out with I. Q.'s above 50. I then ran each group through to see how many birth weights above and below 2,500 grams we had; and the frequency of prematurity, as measured by birth weight, was three or four times higher in the low I. Q. than in the higher and normal I. Q. ranges. This points up very simply and very easily for us the importance of the problem of prematurity in the field of mental retardation, and with a concern for prematurity goes a concern for the whole question of maternal health, obstetrical practices, etc. I think as we learn more about the causes of mental retardation, we will inevitably be drawn closer to those working in the field of maternal and child care, will be drawn closer to the obstetricians who, unfortunately, still do not adequately appreciate the importance of minimal brain damage as a possible dangerous consequence of certain obstetrical practices. Some obstetricians in our New York area still think that a child who cries, moves, and kicks at birth is a normal birth. We learn only two or three years later that many such children have suffered minimal brain injury, which is only revealed in the course of the child's development and not at the time of birth. We think a closer working relationship between the obstetrician and workers in this field may lead to a modification of certain obstetrical practices, at least serve to limit the free use of sedatives and, I suspect, the free use of twilight sleep, and things of that sort, which probably depress respiration. I

have heard leading pediatricians say that twilight sleep is innocuous, "because the only thing that happens is that there is a few seconds longer arrest of respiration before the child starts to breathe," but we know that the capacity of nervous tissue to survive anoxia is sometimes crucially limited in terms of seconds. So, there is a good deal of common work to be done, through our growing insights, in the field of prevention.

Doctor Anderson quite correctly emphasized the importance of a complex differential diagnostic evaluation of the children we are called upon to deal with. This has been the theme of the remarks of most of us so far, and we all wish to break down once and for all the concept of this pseudo-entity of mental retardation. We need to popularize the view that this is a symptom, the end product of many complex causes, and we all feel that every child is entitled to a complex diagnostic evaluation. That does not mean merely pinning the label of mental retardation or an I. Q. number on the child, but a cautiously developed evaluation of all of the factors that enter into the particular problem of that particular child with the recognition that very often even a detailed diagnostic study often will not be enough to settle the problem of diagnostic evaluation. Very often we have to wait for the additional observations that come through working with the child to refine some of the problems that our diagnostic evaluation has raised without answering.

I can query one minor item that Doctor Anderson mentioned, and that is the statement that modern medical science has led to the survival of so many children that would otherwise have expired in bygone days that the number of handicapped children we see might have been increased. I

think a little reflection will remind us that those factors that produce fatalities also produce handicapping conditions, and that by reducing infant deaths, we are not increasing the amount of handicapping conditions, because there is a continuum always from death to minor handicaps. Those factors that produce death always produce a certain number of handicaps, so that improving the infant mortality rate also means diminishing the amount of handicapping conditions because the same factors are involved.

Whenever I leave my own area of activity, I hear mention frequently of the competing interests of the private physician and of the community clinics and public agencies. I do not know what makes the doctors in Brooklyn so different from the doctors elsewhere, but the Brooklyn doctors seem to be glad to have us take this burden off their shoulders and to deal with these difficult time-consuming, long-term problems of rehabilitative work. It seems to me the problem may be exaggerated in certain areas, and if the private practicing physician only appreciated the unremunerative burdens that problems of this type represent to him, he would be more than glad to cooperate with agencies that will do the complex diagnostic work which no private physician in the privacy of his office can hope to do. We can develop a good cooperative working relationship with the private physician, to whom we are glad to send reports, whom we are glad to invite to our conferences, and whose assistance we always welcome, our problem usually being that we cannot enlist this type of participation from the busy practitioner. I do not know why the problem seems practically non-existent in our community and so conspicuous elsewhere.

Our department is affiliated with a medical school. We too take an interest in teaching medical students something about our work. We have found it a useful tactic to introduce the young resident or the medical student to our work, not so much as a specific tour of duty in the field of mental retardation, as an introduction to the importance of rehabilitation in medicine. We tell them and teach them that medicine is no longer so exclusively concerned with the treatment of acute illness; nowadays, the physician is called upon to interest himself in preventive work and rehabilitative work.

Rehabilitative work, as we define it to them, is the promotion of maximal and optimal development in the face of a chronic handicap. We tell the student that whether he deals with a crippled child, or a brain-injured child, or a cerebral palsied child, or a blind child, he will face up to these problems in his medical practice; and it is good for him to learn how to deal with them and especially how to work with community resources to promote optimal and maximal development. It is within this frame of reference that we introduce them to work with children with cerebral handicaps; mental deficiency is probably the most important and common symptom of cerebral handicap. We find that this approach is effective because it is persuasive and valid; we have been able to enlist the interest of pediatrics house staff and of the students by introducing them to rehabilitative work through these channels.

We are proud of the fact that, following a tip from Doctor Thomas, the British expert in mental retardation who visited our clinic some years ago and remarked on the fact that we make too little use of nurses in this country, we have developed a good deal of work with the public

health nurses in our area. Though we initiated the work on our own, under a Demonstration Grant from the National Institute of Mental Health, we have now for five years been working very closely with the splendid Brooklyn Visiting Nurse Association in developing this work: we have two full-time nurses assigned to our clinic. These, in turn, work as liaison nurses with 50 nurses in 50 districts throughout Brooklyn to do home surveys and follow-up rehabilitative work at the home of the many children that we deal with.

I look to the nurse to occupy an increasingly important role in this field, because I am convinced that the medical point of view is important and must not be neglected in this work. Yet, I appreciate that there will never be enough physicians to go round to represent the medical point of view. I think the nurse, by virtue of her training and relationship to the medical profession, has a strategic role to fill in this area; and I think we can expect the nurse to claim her own in this field, not only as the coordinator and assistant to the physician in the clinical setting or within the residential institution, but perhaps also in the occupational or rehabilitation centers as they develop in this country where the nurse will have a key administrative role as she does in England. In many states throughout the country, nurses occupyimportant positions in state health departments and are developing statewide programs in this field. I think we ought to appreciate the significant and potential contribution the nurse can make and encourage her involvement in this work.

Doctor Anderson raised one very weighty and important question in the course of her remarks, the importance of which I would also like to

underscore. She asked, "What are we training these children for? What happens to them when they are no longer children?"

My wife and I (my wife works in a related field) visited some of the splendid cerebral palsy facilities they have in a Los Angeles area some years ago, most of them supported by private philanthropic agencies fully equipped, wonderfully staffed, and beautifully laid out with both indoor and outdoor facilities. When we congratulated the enthusiastic teachers on their fine opportunities and fine work, one of them said, "Unfortunately, when the children reach graduation age, there is no place for them to go. They either end up in custodial care in state institutions or languish at home with nothing else for them to do. Our big problem is not schooling; our big problem is to find a goal for their schooling." I have said very often that if I could have only one wish fulfilled for the mentally retarded, if my fairy godmother appeared before me and said I can have but one wish, and what would it be; I would ask for vocational placement for the young retarded adult, because I think if we solve the problem of vocational placement we would bring into action a whole train of preparatory steps that would set clear-cut goals for our own rehabilitative effort and for the long educational pull.

In the absence of such clearly defined goals, I think our whole rehabilitative work is stymied and drags its feet. This is a very serious question because once we think of vocational placement, we think of sheltered workshops, we think of the touchy problem of government subsidies for working people, competition with private industry, and a whole host of quite ponderable problems.

Let me remind you that similar considerations came up years ago with the problem of prison labor. There, too, we had the spectacle of

prisoners languishing in jails with nothing to do; and when the issue was raised of finding some useful rehabilitative employment for prisoners, a long battle was waged, which was by and large successfully won by those who thought that human considerations come first.

It seems to me we have to turn our attention to this area in the field of mental retardation and must give thought and find solutions to the problem of suitable vocational placement. Many of our young adults cannot survive in private industry, if only because their productivity is a little bit less than the normal worker; in the competitive struggle they stand to lose. Ways must be found either to subsidize private industry to make it worth their while or to provide cooperatives or sheltered workshops for the placement of these potentially useful and productive young adults. I highlight that problem, which Doctor Anderson also emphasized, because it seems to me to be a keystone to many other problems in this field.

I would like also to endorse Doctor Anderson's general emphasis on the community problems that the handicapped children of all sorts share with each other. Some states, such as Kentucky, for example, have found it expedient to set up a statewide commission for the handicapped, to integrate the various needs and problems and solutions which all handicapped children in common need. Whether it is tactically more expedient to emphasize the area of mental retardation or to group the retarded child's problems with those of other handicapped children, I do not know. Local conditions will dictate which tactic is the best; but taking the long view, I think we must look ahead to the time where the integrated approach on a statewide level will have to be developed

for the provision of the community needs of all handicapped children. It may be tactically desirable to do it piecemeal fashion--first with the retarded, then with the cerebral palsied, then with the blind, etc., but other local conditions may suggest a more comprehensive solution to this problem.

I have found myself in happy agreement with all that Doctor Hargrove has said; I think he, too, can be congratulated for the sound point of view that has been developed here and for the rapid progress the state has achieved in fulfilling its objectives.

I perhaps would have liked him to develop a little more his notion of the change of the custodial institution into a true hospital and true rehabilitative center. He spoke of the return of the patient back to the community. I think if we conceive of services as being organized in some coherent, logical, and integrated fashion, we should begin to think in terms of a back and forth movement between the community and the residential institutions. There will be occasions when children cared for on a community level will need a period of residential placement after which they can return to the community clinic or community school for the further development of the rehabilitative plan. Conversely, there may be periods where the child in a residential institution can be placed for a trial period in the community setting where there can be a carry-over of care and planning through the community facility.

Ideally, we would have an integrated plan whereby the residential facility is just one resource in the complex of services and will no longer represent the deadend, the final solution of "putting the child away," which has so many forbidding connotations to the parents and has

in fact so often in the past represented the last and final step in dealing with the problem. Even in New York state, there are many barriers to this type of interrelationship between the community clinic and the state institution, which have developed because of certain traditions of administration and budgeting; but we hope in our own community to solve this problem so that there can be an easier back and forth movement between the residential facility and the community clinic.

In the process of picturing the residential institution as a hospital for treatment, the very nature of the residential institution has changed. The fact that here in North Carolina you are developing out-patient clinics in your residential centers marks the direction of change, and we have found in New York state that it is practicable and expedient to allow many of the young adults to leave these residential centers to work in the outlying communities on a day basis on the farms, returning to the residential center in the evening so that there, too, the residential center, far from being a shut-in place for the retarded, becomes a home for the retarded who actually live in the community. I think by creating smaller residential institutions, by integrating them better into the community in which they live, they too can partake of the benefits of community life, and will serve no longer to isolate the young retarded adult from the community, but will serve on the contrary to promote his integration into normal community life.

There are big opportunities in a state the size of North Carolina which is not burdened by the large numbers we have to deal with in New York state. You can meet each other more easily; you can plan more readily than we can in New York state, and I think with the attraction

of young and enthusiastic people into the field, a great deal can be done, not only in the improvement of services, but in the development of research programs.

One of the things that some of the states are beginning to do is to develop unitary case records for the use of clinics and residential institutions alike, so that data can be pooled, analyzed, collated, and long-term follow-up studies done with those wonderful computers that we have and which are said to be able to solve all our problems. I think it is not too early to think of the development of coding schedules and punch card forms which will not only assure completeness of study of the children but will allow collation, comparison, and analysis of data in ways that, I am sure, will be fruitful not only from an administrative point of view but from a research point of view as well.

In all of the complex of things which have been said, I would like, by way of summary, to highlight three central themes: (1) First is the great importance of conducting a factor analysis of the problem of each retarded child. The factor analysis can go as deeply into detail as our medical technology allows us to do. It involves not only an appraisal of how much is psychological, how much social, and how much physiological, but I think the time is approaching where even in our understanding of the physiology or pathophysiology of the handicapped, a great deal more can be done than has been done up to now.

I have in my hands now a manuscript of a book by a Russian expert in the field of what they call defectology, Doctor Pevsner, a woman physician whom I met in Moscow a couple of years ago, on the problem of mental deficiency. Now that the prestige of Russian technology is high,

and competitive interest is keen, it is good to spread the word that the Russians are doing very ingenious things in the field of the mentally retarded child. By using physiological techniques, they are moving pretty rapidly ahead of us into the area of an ingenious patho-physiological type of factor analysis of the problem of each retarded child that should arouse our interest and emulate our competition.

The book by Doctor Pevsner will be out in print in a few months, I expect. (Published by Consultants Bureau in New York) But what it says is that it is nowadays possible to measure the attentive capacity of a child through plethysmographic techniques which Professor Sokolov who visited this country last year told us about. It is possible to measure the fatigueability of a child by these techniques. It is possible to analyze capacities of the brain, and, I think, by the use of these and similar techniques, we will succeed even further in breaking down the pseudo-entity of mental retardation into a group of specific pathophysiological handicaps, which lend themselves to special educational approaches and which will not only enhance our insights but improve our work with these children. So, I would like to emphasize the importance of a type of factorial analysis of the problem of each child along the lines that the other speakers have indicated, but with perhaps even further refinement of our techniques.

(2) Let us as physicians recognize that the single big need for this group of children is in the educational field. The medical skills that we bring to bear on this problem are important but, at the present stage of our knowledge, are not of primary importance. We lose perspective if we think of the problem of mental deficiency in its broad outlines as

primarily a medical problem. It is potentially a medical problem; it is incidentally a medical problem, and the physician has an important role in integrating all of the various aspects of the work that enter into this field; but, in terms of daily helpful activity, the teacher has a key role and will continue to have a key role for a long time to come.

This means that we must develop very close working relationships with the educational authorities; we must lean heavily upon the teachers for help, and we must encourage the teachers to take a responsible position of leadership in this field and not live from handouts from the doctors and psychologists who will tell the teacher what to do. I find that the teachers have very big resources of skill and experience and knowledge that has come out of intimate relationship with this work. They tend to be very modest and unsophisticated in their own self-appraisal, but they have skills which need to be recognized and utilized.

Particularly now, when we speak of shortages of personnel, I think there are rich resources in the educational profession that are ready to be used. So that the second thing I would like to emphasize is the importance of education.

(3) And, finally, the third thing which I already emphasized is the key importance of the solution of the problem of vocational placement.

Wednesday Morning Discussion -- Proceeding from Doctor Wortis' response was a discussion of community responsibility. A fair concensus was in evidence that mental retardation is a community problem best handled close to the community, if not in it. Interagency overlap was discussed with respect to needs for coordinated effort. The Minnesota Guardianship plan came up as an example of an attempt on the part of a state to provide continuity of care for the individual. How a plan of this sort could work smoothly without usurping individual rights could not be clarified.

The feeling of parents was well put by this question from a parent representative: "Is there any one place a parent can turn for help?" An adequate answer for this question was not available, although in many communities coordinated efforts have begun and guidance made available. The value of lay organization was emphasized with clear recognition that parent groups have been the prime motivating forces within communities. Local interest will be an important determining factor in the adequacy of programing. Final answers cannot come entirely from state levels, although guidance and support can.

Mention was made of the need for the obstetrician and general physician to know the facts about causes of mental retardation and help in prevention. It was aptly pointed out that no obstetrician was at the workshop; Doctor Vernon accepted responsibility for this oversight.

2:00 p.m. Wednesday -- Beginning the Wednesday afternoon session Doctor Nisonger from Ohio State University gave an overview of the current scene in special education.

Doctor Nisonger's field is education; his specialty is special education. It was a privilege to have him on our program because of the wealth of experience he brings and his youthful attitude. His presence provided a perspective which was sobering and stimulating; his sagacity kept us from wandering too far into the clouds.

Following Doctor Nisonger's talk, Mr. Felix Barker from North Carolina's Department of Public Instruction described this state's educational program and plans for the retarded, and Mr. Gareth Thorne from the Hospitals Board of Control described the educational programs and plans in the residential centers (i.e., schools).

# THE CURRENT SCENE IN SPECIAL EDUCATION

by

Herschel W. Nisonger, Ph. D.

There have been three significant epochs in the historical development of special education programs for the mentally retarded in this country. The first epoch began about the middle of the last century with the establishment of public residential institutions. Near the turn of the century special classes for educable mentally retarded began to appear in the public schools. The most recent development has been publicly supported special class programs for trainable mentally retarded children. It should be pointed out that private agencies pioneered in each of these areas and in some degree have maintained parallel programs but after the need was demonstrated public support was forthcoming.

## 1. State Residential Institutions

The first public residential institution in this country was the Walter E. Fernald State School at Waltham, Massachusetts, established in 1847. At this time practically no suitable facilities for the care and training of the mentally retarded were available in communities, so the states began to take on this responsibility. The growth of institutions was slow in the beginning, but by 1900 they numbered 21, reaching from Massachusetts to California. By 1925 they had increased to 64, by 1950 to 84. The number now exceeds 100. With the exception of Alaska and Nevada all states now maintain from one to seven institutions.

The original purpose of state residential institutions was to provide relatively short-term education and training for high grade, educable mentally retarded individuals and return them to the community. Although they served other essential functions their primary purpose was education and training. In line with this purpose most of them were designated as schools which is true in your state.

However, over the years the role of residential institutions has been subject to a gradual change. This is due to several factors. The rapid expansion of services at the community level, especially in the larger centers of population, has been followed by noticeable changes in the composition of new admissions to the institutions. The proportion of high grade educable individuals who could be trained and returned to the community have sharply decreased and those with severe mental, physical, emotional, and personality defects have increased. This has forced many institutions especially in the more heavily populated states to shift their focus from primarily "school functions" to more "hospital type functions" in order to meet the needs of the changed composition of institutional populations.

The growth of community services has affected the changing role of state residential institutions in other ways. In the early days the residential institution was the only specialized resource available for the care and training of the mentally retarded. Today residential institutions are regarded as only one among the total resources within a state which are available to those who are responsible for planning and placement of mentally retarded individuals for services which best meet their specific needs. As our understanding and knowledge of the specific needs

of the mentally retarded expands and our skills in planning and selective placement in appropriate services increases we will be able to utilize all available resources more effectively.

The state residential institutions have made a significant contribution to the development of special education in the past. They are destined to continue to do so in the future. However, as indicated above their specific role in a total state program for the mentally retarded has been and still is undergoing transition. What it will be 25 years from now we can only speculate on the basis of current trends.

2. Public School Programs for Educable

Special classes for the educable mentally retarded began to appear in some of the larger cities near the turn of the century. This movement was motivated by a recognition on the part of school administrators and teachers that many mentally slow pupils in school could not succeed in the regular academic school program and were confronted with continuous failure. As a result special classes were established for these pupils with modified curricula and learning experiences. At first there was a tendency to place in these classes all pupils who were failing in school. Later refinements included only those with detectable retarded mental development.

Educable mentally retarded usually show a rate of intellectual development which is approximately one-half to three-fourths of that expected of one of the same chronological age. Expressed in terms of I. Q. states usually interpret the limits as a floor of 50 or 55 to a ceiling of 70 or 75.

Prevalence studies show that the percentage of the educably mentally retarded varies widely among school systems but the generally accepted average is approximately two and one-half per cent of the school age population, or 25 per 1,000.

In the beginning special classes were confined to the elementary schools. Even older adolescents who remained in school were retained in these classes largely because their academic achievement levels were near the fourth to sixth grade levels.

More recently special class programs with modified curricula have been developed in many of the junior and senior high schools. As a result these pupils are able to move up into the secondary school with their own peer age groups and as a consequence stay in school longer.

Mr. W. Kuhn Barnett, Director of Special Education in Virginia, has characterized the developing program in this area as follows:[1]

"A planned special education program for the mildly retarded (educable) children includes 12 years of school experience. It provides for the kind of practical training and education that will keep children in school and prepare them for their role as contributing citizens. The objectives and goals of such a program are to encourage the achievement and mastery of academic skills commensurate with the child's mental capacity. Emphasis is placed upon the communicative skills, pretraining in occupational skills which will enable the child to get and hold a

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[1]Barnett, W. Kuhn., Preparation of mentally retarded youth for gainful employment. Report of a conference sponsored jointly by U. S. Office of Education, Office of Vocational Rehabilitation, AAMD Project on Technical Planning in Mental Retardation, Superintendent of Documents, Bul. No. 28, 1959.

job, and development of personality traits which will assist the child to grow into an acceptable and contributing member of his community.

In order to realize these objectives, a 12-year program is usually organized in four age groupings: primary, intermediate, junior high school and senior high school.

In the junior high age group school experiences are related to vocational interests and to the need for information concerning jobs. Knowledge as to the nature of probable work opportunities is emphasized.

At the age of about 16, children are encouraged to enter the last phase of the educational experience, the senior high age group. This advancement is based on the assumption that they are now ready for a work-school type of program. At this level school and employer plan together with each child who works part time and attends school part time. The classroom activities are closely related to the work experience. Such things as filling out application forms, applying for work permits, and personal conduct during interviews with employers receive attention.

Follow-up studies indicate that most mentally retarded individuals, with this kind of training, achieve economic and social independence in adult life. There are some who will need further training beyond school. Some schools have established working relations with the state rehabilitation agency to which those needing further training are referred.

While the movement began near the turn of the century most of the growth has taken place during the past 25 years. It was in the late 1930's and early 1940's when states began to amend their special education laws to include provisions for the educable mentally retarded. At present all states have such provisions backed up with varying amounts of financial

support, although improved programs in rural areas are still quite inadequate due to administrative difficulties. Programs in the secondary schools including work-school programs are growing rapidly but still spotty. Teacher education programs are improving and expanding, but there is an acute shortage of well-trained teachers. Probably half of the teachers now employed in this area cannot meet the minimum standards of training as set by the better teacher education institutions.

It is estimated that approximately one-third of the eligible educable mentally retarded children and youth are now enrolled in special class programs. This is a tremendous challenge for the future.

3. Programs for the Trainable

Special class programs began to appear under private auspices in the early 1930's. The movement was stimulated largely by parents whose children had been excluded from the public schools.

Trainable mentally retarded individuals usually show a mental level and rate of development of one-fourth to one-half of that of the average normal child. Expressed in terms of I. Q., states usually interpret the limits as a floor of 25 to 30 to a ceiling of 50 to 55. Prevalence studies indicate that one may expect to find 3 to 4 per 1,000 in the school age population.

The objectives of special class programs for the trainable are quite different from those for the educable. As indicated above, with adequate school programs including orientation into employment and adult life, most of the educable can be expected to achieve economic and social independence as adults. Some of the trainable may achieve partial independence but most, if not all, will require a life-long sheltered environment and the supervision of mature adults.

Miss Baumgartner characterizes these children as follows:[2]

"a. Their speech and language abilities are distinctly limited, but they can be taught to make their wants known.
b. They are generally not capable of learning academic skills, such as reading and arithmetic beyond the role learning of some words or simple numbers.
c. They are capable of learning to get along in the family and in the immediate neighborhood by learning to share, to respect property rights, and in general to cooperate with their families and neighbors although they cannot be expected to become self-sufficient in making major decisions.
d. They are capable of eventually learning self care in personal routines, good health habits, safety, and other necessary skills which will make them more independent of their parents.
e. They are capable of learning to assist in chores around the house and/or in doing a routine task for some remuneration in a sheltered environment.
f. They will require care, supervision, economic support throughout their lives."

The first state to make legal provisions for special class programs in the public schools, did so in 1949. In ten years the number had increased to 39. Thirty-eight states placed the administrative responsibility in Education. One exception (Ohio) placed it in Mental Hygiene. If past growth is any indication of future growth, we must expect this program to be established in all of the states in the next few years.

The development of special class programs for trainable faces many problems comparable to those for the educable. Expansion into rural areas has been difficult and expensive because of administrative and transportation problems. The demand for well-trained teachers far exceeds the supply. Facilities for training teachers for these classes are very limited. Our knowledge about these children and how to teach them is quite limited. This makes it very difficult to prescribe a teacher education program with any degree of understanding and security.

4. Other Related Developments

There are certain other significant services which are either basic to or supplementary to programs in special education. Examples are:

a. Diagnostic Services

What has been said about the rapid growth of special education programs in this country also applies to the expansion of diagnostic services. These include diagnostic services provided by the family physician, child study services in the schools, hospital, and university clinics, state, regional, and community clinics, traveling clinics, out-patient services of residential institutions, etc. Some are specialized clinics for the mentally retarded while others are general in nature.

Although available diagnostic services have greatly increased in most states, they are largely confined to the larger centers of population, the diagnosis is often piecemeal and lacks coordination, results are frequently not adequately interpreted to parents, teachers, and others who must deal with the individuals concerned; and many general mental health clinics have no staff with special interest and training in mental retardation. In planning statewide programs for the mentally retarded, adequate diagnostic services must be considered as one of the keystones to progress.

b. Sheltered Workshops

I have already described the progress made in providing special class programs for trainable children. What provision

can be made for them after they leave these classes? Since they will not be able to enter competitive employment, the only solution is to provide some kind of sheltered employment.

During the last decade many communities have established sheltered workshops under private auspices. Some approaches have been made to state legislatures to secure funds for this purpose. So far as I am aware no legislature has made such provisions, but it doubtless will come.

c. Home Training Services

Parents of severely retarded children face many frustrating problems of training these children with which they are unprepared to deal. Nursery schools for these children are usually not available. Special classes for the trainable usually do not admit them until six or seven years old. One possible solution to this problem is provision for home training services.

A few states have established home training and parent counselling services to families of children who have been committed to residential institutions and are on the waiting lists for admission. Ohio has provision for home visitors as a supplement to its special class program for trainable children.

# EDUCATIONAL RESOURCES FOR THE MENTALLY RETARDED IN THE PUBLIC SCHOOLS OF NORTH CAROLINA

by

Felix S. Barker

## Basic Philosophy

North Carolina is committed to the principle of education for all children regardless of variance in abilities. The belief that every child should be provided with an educational opportunity consistent with his capacity to learn is the basis for all sound programs of education for exceptional children. This point of view necessitates the establishment of a learning environment based on an understanding of individual differences and a knowledge of the educational implications of these differences. This point of view also demands programs and facilities which will meet the specific needs of each child.

It is expected that reasonable ranges of individual differences will be provided in the regular classroom. For those children who are intellectually handicapped (mentally retarded) to the extent that they cannot be handled in the regular classroom and require services different from or in addition to those provided for average children, the public schools of North Carolina are attempting to organize and provide such services as will meet their needs through a program of special education.

While the broad objectives of education are much the same for all children, the normal or the handicapped, the whole purpose of special education is to help each child compensate for his disability, to remove or minimize his limitations, to increase his capacities, and then to

provide those individual opportunities and specialized services from which he can benefit most within the range of what he can do and what he can become.

The responsibility of special education is to provide for these children within the public school system, to see to it that they are not unnecessarily isolated from children of their own age, and to find ways for them to participate within the limits of their capabilities, in activities and learning experiences with other children.

Meeting the needs of exceptional children involves much intercommunication between the personnel of special services and the teachers of regular classes. Teachers in regular classrooms share responsibility for many children with physical and mental limitations; this calls for mutual understanding and cooperation between themselves and the special teacher.

Education for exceptional children should be a part of the regular program of the public schools. It should not be isolated within a school or a school system. Special education has too many problems in common with the regular program of elementary and secondary education to justify its organization apart from these areas. Close working relationship on the part of all persons concerned with the education of children may bring to light resources that have not been previously recognized. Regular classroom teachers should understand that special classes are for children who have certain problems that cannot be met in the regular classroom. Equally important, the regular teacher must realize that many of the needs of special students can and must be met in the regular classroom.

Flexibility is essential in a program which meets the varying needs of children. If a child can benefit from placement in a regular class and can be accepted in it, he should be there. If he can make better progress in a special class, or if his presence in a regular class adversely affects its progress, he should be placed where his problems can best be met.

Educable Mentally Retarded

Teachers of retarded children, as well as other public school personnel, should not mislead parents or interested persons by holding out false hopes as to how much education such children can achieve. Though the child will probably remain retarded, it should be made clear that the handicap as such may become less important to the child, the family, and the school, and to the community as a result of a special education program. The child becomes important as an individual with the opportunities that are provided for him to achieve in a special class.

There are so many degrees and types of mental retardation that no single definition could include them all. Reduced to its simplest form, mental retardation means impaired or incomplete mental development and reduced capacity for learning. It is common practice for educators and psychologists to classify children with intelligence quotients below 75 and with mental ages of one-fourth to three-fourths their chronological age as mentally retarded. There is general agreement that the division point between educable and trainable pupils in terms of special education classes in the public schools falls somewhere near an I. Q. of 50. Pupils whose intelligence quotients falls below 50 are generally

considered to be unable to attain any effectual mastery of words or numbers.

There is also general agreement that the number of mentally retarded children in increasing and that their life span is lengthening. One of the reasons for the increase is that modern medical techniques have decreased infant mortality among premature births and among children born with congenital defects. At the same time, medical science has not made similar advances in the prevention of mental retardation.

It is reliably estimated that between two and three of every one hundred persons in the total population have intelligence quotients within the range from about 50 to 70 or 75, which places them in the classification of the Educable Mentally Retarded. Under favorable conditions they may be expected to achieve third to fifth grade levels of academic skills by the time they are sixteen years of age, with corresponding mental ages of from 8 to 11 years as adult persons. This is the mildest degree of "mental retardation" and at the upper levels it is not easily distinguishable from marginal normality. However, the low levels shade into the "trainable," or non-educable, group.

Surveys indicate that while approximately 70 per cent of the educable retarded group who have I. Q.'s of 60 and above become occupationally self-supporting, usually in unskilled jobs, they are distinctly handicapped in the traditional academic school curriculum. Their readiness for academic school work is delayed. As an illustration, a child with an I. Q. of 60 might not be ready to learn to read or to understand simple arithmetic until he is 10 or 11 years of age (the normal fourth

or fifth grade age level). In the ordinary school classroom the academic handicaps of such children may result in great frustration, feelings of inferiority, undesirable behavior, and any other adverse personality characteristics more serious than the intellectual retardation itself.

In order to help provide such public school children with academic and social education in accordance with their abilities and needs, specially trained teachers and special classes of limited size are needed for these children. Recent surveys indicate that there are approximately 28,000 educable mentally retarded children in the public school population of North Carolina. The State is a long way from meeting the needs of such numbers of these children, or even of positively identifying all of them. During the 1960-61 school year, state funds were provided for the salaries of 108 special education teachers who taught approximately 1,800 educable mentally retarded children in 69 of the state's 173 county and city educational units. Add to this approximately 85 special class teachers employed from local funds, the total number of such special class teachers in North Carolina is 193, serving approximately 3,900 children. Considerably less than half of the school administrative units in the state have even one special class teacher for the educable retarded, and in no unit are the needs being completely met for such teachers. Additional teachers, however, no matter how well-trained, will not in themselves solve the problem. Additional classroom space and funds for special books, materials, and proper psychological identification of the retarded are also needed.

Most of the educable retarded children in North Carolina are now in regular classrooms where the teacher cannot give them sufficient

time if the needs of other children are to be respected. Retarded children demand much repetition and a less abstract, more concrete approach if they are to learn school subjects. Because they have had to repeat one or more grades, they are usually several years older than their classmates, but are not able to learn as quickly. Their individual needs and interests are often neglected, and they spend much of their time "just sitting," disinterested and bored with the regular classroom work and often developing into emotional and behavior problems which upset the routine and disturbs the progress of the entire class. They are usually children who want to "quit school" as soon as they reach the age of sixteen, because the school has nothing to offer them. And yet, they may be the youth who at that age, are least ready emotionally or socially to be on their own in the community, and most in need of the two or three additional years of maturation which a suitable school environment might give them.

With special instruction most educable retarded children can be educated to the point that they are employable and capable of self-support. Prospects for improving public school opportunities for educable mentally retarded children are good. Parents, educators, legislators, and other groups concerned are developing a sensitivity to and a better understanding of the problems involved.

Programing for the educable mentally retarded consists of emphasis in the following areas: language arts, including reading, writing, and spelling; arithmetic; science; social studies, including health and safety; and creative and practical arts and crafts. Books and materials appropriate to the individual abilities and interests of the pupils are

utilized. The goals of this educational program include the development in each student of the fullest possible personal development, academic growth, social responsibility, and economic independence.

Programs for Trainable Mentally Retarded

The classification of trainable mentally handicapped applies to those children who are retarded to the extent that they have been traditionally excluded from the public schools as being uneducable. This term refers particularly to their limited ability to learn to read, to write, or to use arithmetic for socially useful purposes. Another broad generality is that they are not likely to have sufficient general ability or intellect to become independent, responsible citizens. Traditionally, also, they have been considered as candidates for residential schools, or institutions for the "feeble-minded."

There seems to be much confusion as to how many of these children there are in the communities and as to what are reasonable estimates of the total number in the state of North Carolina. There are some recent authoritative studies giving data on the incidence of the trainable mentally handicapped child. These indicate about 0.3 per cent of school age children may be expected to be within this group of children having intelligence quotients from 25 to 50. If these percentages of incidence are applied to the school age population, it can be expected that there are between 2,500 and 3,000 trainable mentally handicapped children in North Carolina.

A few classes for trainable mentally retarded children began to appear in North Carolina during the year 1954 and 1955. These were organized and operated by local parent groups. In some situations

local civic organizations contributed financial support. By 1956, there were approximately ten (10) of these centers operating entirely with private funds.

In order to continue to operate these centers and to establish others where needed, it was recognized that state aid would be needed. The 1957 General Assembly of North Carolina enacted legislation to enable county and city boards of education to operate day centers for trainable mentally retarded children. For the first time in the history of the state, the public school system was authorized to assume responsibility for children below the educable level.

The law requires that classes be administered by the local superintendent of schools. It was necessary, therefore, that some time be taken in transferring responsibility for administrative and supervisory functioning from local parent groups to the superintendent. It was also necessary that the local groups formerly operating the classes reorganize for their essential functions of continuing community interest and support and to serve more in an advisory capacity. Continued financial support of the community was essential since state aid would amount to approximately half the cost of operating a center.

Legislation became effective July 1, 1957, and by early fall of that year 18 classes with an enrollment of 342 children were in operation. At the present time, state aid is allocated to 42 school administrative units that sponsor 75 classes in which approximately 900 children receive their training. Although great strides have been made since the inception of this program, an even greater need exists as evidenced by the fact that 131 school administrative units still do not have facilities for the trainable mentally retarded.

Programing for the trainable mentally retarded consists of emphasis in the following areas: academic training, including simple number work, writing, recognizing words and thinking; practical skills, including household chores, menial job training, recognizing danger, and a sense of direction; communication skills, including listening, watching, imitating, naming, using and understanding language; and self-help routines, including personal grooming, health habits, and safety routines.

This sort of program must be purposeful and as such makes a realistic and practical contribution to the child and society. By helping the child to develop his potentialities in all areas of endeavor, he will be better prepared to find and accept his ultimate place in society.

There is some concern at the present time in regard to raising the age limit of eligibility for the trainable from 18 to 21. Making such a change will involve additional program planning for these older children along the lines of vocational preparation.

Consideration is being given to further development of public school work experience programs or other types of vocational training for educable mentally retarded children of high school age.

In general, it is felt that the quality of work being done with the mentally retarded in the public schools of North Carolina is good; but, until some of the existing gaps can be filled, it cannot be said that a complete job is being done.

# TRAINING AND EDUCATIONAL PROGRAMING IN NORTH CAROLINA STATE RESIDENTIAL SCHOOLS FOR MENTALLY RETARDED

by

Gareth D. Thorne

Training and educational programing within state residential schools for the mentally retarded needs to be, and is in North Carolina state schools, conceived and conducted as an integral part of the total residential school community, and is directed towards the intellectual, emotional, physical, social, and vocational growth of each resident. In order that training and educational programing provides maximum service, it is essential that training and education staff be fully aware of, and in accord with, the general objectives, philosophy, and administration of the residential school.

In each of our state residential schools the training and education program is a clearly defined department with responsibility for designing, implementing, and supervising programs suited to the education, training, and recreational needs of the school population.

In general the major objective of the overall training and education services is to provide maximum educational opportunity for each resident so that he may acquire those skills and knowledges essential to leading a happy and productive life outside the residential school, or when necessary, a happy, and when possible, rewarding and productive life within the residential school.

A primary prerequisite to quality training and education in our state school training and education programs is the employment of well-qualified staff.

At the present time all training and education positions in our schools are set up under the State Personnel Department plan which determines employment criteria, job description and duties, and salary ranges. All our state residential schools require that teachers be certified through the State Department of Public Instruction, and hold a certificate in the area of instruction comparable to that required in public school programs. Salary schedules for our teachers are also comparable to public school teachers' salaries at this time.

One of the most important factors in the achievement of our present level of programing has been the cooperative work carried on between Training and Education Departments within our three state schools, which is indicative of a continuous effort to provide equivalent programing in each school. One result of this interschool cooperative effort has been the development of a brochure on "Recommended Minimal Standards for Training and Education Programing," which serves as a broad guide to program planning and operation ranging from type of facility to recommended textbooks. Another achievement of interschool cooperation has been the development of a "Curriculum Objectives and Materials Guide" for academic programing at all levels with educable pupils. Still another achievement of interschool cooperation is the development of uniform pupil class assignment criteria, and uniform testing and reporting systems pertaining to training and education services.

Prior to this year two annual conferences were held for all training and education personnel which served greatly to enhance the professional growth as well as the morale of training and education

staff. Unfortunately during the past year these meetings were discontinued, and it is to be hoped that this very constructive interschool activity will be resumed in the near future.

In speaking of cooperative programs between schools, I should like to point up that aside from interresidential school cooperation we also have close liaison and cooperation with the SEC on Education of Exceptional Children, State Department of Public Instruction. This relationship has been very beneficial to us,and our state residential schools have always been invited to participate actively in special education meetings and conferences sponsored by the SEC on Exceptional Children. I think this is a good example of teamwork in total educational programing for mentally retarded.

I should like now to speak more specifically about the training and education services in our three state residential schools. The Training and Education Departments are organized mainly at this time to provide services to two groups of residents, those classified as educable and those classified as trainable and further to provide recreational services to all residents. Our distinction between educable and trainable groups is based mainly on the capacity of some pupils to profit from more formal education versus those who cannot, and as well a program plan which embraces the ultimate possibility of rehabilitation versus the possibility of habilitation to life within the residential school. At this time, generally speaking, our greatest efforts are being extended to services for our educable pupils primarily because they have greater and more complex educational needs and because there is excellent reason to believe that most of these will be rehabilitated.

On the other hand, programing for trainable retarded pupils is developing rapidly into an equally important aspect of our program particularly as we consider these pupils potential candidates for sheltered workshop programs, and as we recognize the more important role trainable pupils will assume in the future as adults within the residential school community.

PROGRAMING FOR EDUCABLE PUPILS

The objectives and scope of our programing for educable pupils includes at least the following: intellectual development and proficiency in academic tool subjects; the development of emotional stability, good habits of health and personal hygiene; personal and social adequacy; interest, attitudes and skills leading to good citizenship and community responsibility; learning habits and skills necessary for the purpose of earning a living and finally wholesome use of leisure time.

The program for educables includes the following array of educational activities:

1. Academic school classes
2. Music instruction
3. Arts and crafts
4. Home Economics and/or Industrial Arts
5. Library services
6. Physical education and recreation
7. Prevocational and vocational training

Most academic classes are coeducational and composed of homogenous groupings of pupils according to age, I. Q., and reading achievement level. A new criteria to be added is the rate of achievement in the prior school year.

A comprehensive record system is maintained on all pupils and includes records of achievement tests, report cards, evaluation of student progress in academic classes, and school adjustment and performance reports. Anecdotal records are maintained on most pupils in academic classes and related areas.

The facilities for education programing in all of our state institutional schools are for the main part very adequate, or will be so upon the completion of current construction.

The academic school program is offered to pupils age 6 through 18 and comprises an ungraded system. The academic program is divided into four basic levels, i.e., the kindergarten level for pupils between ages 6 and 9; the primary class level for pupils between ages 8 and 10; intermediate level for pupils between ages 10 and 14; and the secondary level for pupils between ages 14 and 18+.

The academic curriculum covers the following areas of instruction:

1. Social growth and development
2. Academic readiness programs
3. Physical growth and health
4. Mental health
5. The development of basic skills and functional use of tool subjects, reading, writing, and arithmetic.
6. Psychological growth
7. Prevocational training and preparation for rehabilitation

In addition to the basis academic program for educable pupils, other essential activities are combined with the daily school program. These include:

1. Music classes which provide opportunity for each pupil to learn an appreciation of all forms of musical expression, and music as a medium of creative expression. Further the music program provides in some cases opportunities for simple instrumental training, and training in dance and special vocal activities.

2. Arts and Crafts including industrial arts provides for the development of creative and practical skills and talents which we hope will enable the pupils to ultimately find a suitable outlet for his talents, skills, and interests in work and leisure time.
3. Library Services and facilities are well developed in most of our programs for the purpose of providing pupils with reading materials suitable for academic and leisure time pursuits, and as a reference source for pupil and staff alike. The libraries also stock and maintain film and record supplies, correlating these materials with academic subject matter and activities.
4. Physical Education classes are offered all educable pupils for the purpose of developing physical fitness and coordination, character development and the wholesome use of leisure time.

In addition to the activity areas mentioned above which are included in the regular academic school program for educables, other activities are provided for educable pupils in varying amounts according to his needs. These activities are Home Economics and Vocational Training. We generally consider these phases of training as special areas of service extended primarily to older pupils (intermediate and secondary) for the purpose of helping them acquire special skills in a vocational and domestic life.

The objectives and purposes of home economics programs is to help pupils acquire knowledge and skills relevant to family planning and management, housekeeping, maintenance of home and yard, food preparation and service, child care, health, personal grooming and dress, procurement of foods, clothing, household supplies and equipment, and budgeting time and monies. Basically this program is concerned with the development of responsibility for those things essential to happy, productive home life and management, either as a family member or employed domestic.

The vocational training program covers a broad area of activities wherein the main objective is to provide realistic training opportunities

in unskilled and semi-skilled occupations leading to vocational adequacy. The vocational training program includes an analysis of individual skills, aptitudes, and interests, through the services of vocational guidance counselors and/or teachers. Vocational instruction is usually offered through a cooperative arrangement with various residence school work areas, wherein the pupil works part time on a job during the school hours. In many cases the pupil has completed formal academic training and spends a full day in vocational training. Often times pupils evidence particular interest and ability to learn specific semi-skilled or skilled occupations, such as snoe repairman, tradesman as trades helper, cafe or food service worker, practical nurse, or nurse's helper, domestic, etc. Whenever possible special training programs are offered leading to proficiency in occupations such as listed above. In addition to the pupil benefits gained from vocational experience in institutional work areas, the institutional staff is supplemented with student help so that a more economical operation of the institution is made possible through the contribution of pupil labor. There is indeed some question as to the adequacy of such a plan of programing wherein pupils are utilized as an essential part of the institutional labor force. There is always the question of whether the pupil receives adequate attention and instruction from the work area supervisor, who usually is not a member of the training and education staff, and whether or not the job to be done is regarded as primary, rather than the instruction of the pupil. On the other hand, some argue that such training conditions are realistic and the pupils learn more effectively under these circumstances. It is also argued

that the pupil experiences a feeling of being a contributing worthwhile member of the residential school community.

At this point there is need for more study of these arguments pro and con, with perhaps the possibility of drawing a compromise between two points of view, and incorporating the positive aspects of both into a more workable and acceptable program.

Educable level pupils, as well as all other residents have opportunity and are encouraged to participate in our well-organized and developed recreation programs. Our facilities are very adequate for the most part with each school having a well-equipped recreation building or gymnatorium. The objectives and purposes of the recreation program is to provide each pupil the opportunity to participate in enjoyable leisure time activities and to promote mental and physical health through interesting and worthwhile recreational pursuits. Some examples of typical recreation activities are: dances, movies, competitive sports, social hours, parties, etc. Outside and seasonal recreational activities include swimming, tennis, and miniature golf at some of our state schools. All schools have outdoor playgrounds, ball grounds, and campsites, and in special instances, skating rinks, and go-cart race tracks are provided.

Other activities usually participated in by educable pupils include the following: (1) Competitive sports and field events with local public schools, churches and city recreation programs. (2) Special activities in music such as glee clubs, choirs, etc. (3) Assembly programs. (4) Student government activities such as an elected student council which serves to assist the school staff in planning and

maintaining school activities and facilities and a school patrol responsible for assisting in the supervision of pupils going to and from school safely, and maintaining proper order and conduct inside and outside the school.

In summary - generally speaking our programing for educable pupils is progressing and developing satisfactorily. It is true that there are some definite areas of weak planning or programing. The schools are not equivalent in all aspects of programing. For example, some have more comprehensive academic programs than others. The lack of equivalent programing is due mainly to differences in age of program operation, number and diversity of staff, type of facility, and available supplies and materials. It is important to consider, however, that the differences between programs in our schools is diminishing at a rapid pace.

Those factors of program inadequacy that are more or less general to all schools are, insufficient number of staff, high daily pupil-teacher ratio, and insufficient time spent in academic and other classes. Further, we need to spend more time in research, and program evaluation and planning. Insufficient staff is again principally involved here, but perhaps this could be circumvented through cooperative programs of training and research with the universities and colleges.

Another area of comparative program inadequacy is in vocational training. There can be little doubt that rapid strides are being made to improve present vocational training programs but at present we have insufficient staff, and in some instances insufficient facility, to

carry on the type of vocational program we feel is appropriate to the needs of the pupils.

PROGRAMING FOR TRAINABLE

Uniform training and education programing for trainable pupils has not yet been achieved by our three state residential schools. At this time each school is pursuing independent study and planning concerning programing for trainable pupils. Within recent months many new ideas and plans have been developed. The present plans for developing a uniform program calls for a series of conferences between training and education personnel from the three schools wherein each school program will be studied with the possibility of combining the strong points of each program into a recommended uniform program plan.

Characteristically in years past, programing for trainable pupils in residential schools centered mainly about an elaborate arts and crafts type activity. In many ways these programs resembled occupational therapy activities carried on in state hospitals.

Today programing within our schools for trainables is predicated on the need to help trainable pupils to achieve as high a level of self help as possible, to help each pupil to acquire such skills necessary to useful, worthwhile, and rewarding occupation within the residential school, or possibly a sheltered workshop. Incorporated within these major objectives are social growth, mental health, physical development and opportunity for pursuit of leisure time activities sufficient to continued happiness and adjustment.

Training and education programs within each of our residential schools provides scheduled classes for trainable pupils. These classes

meet daily in most instances, are homogenously formed according to age, I. Q., are small - usually 8 to 12 pupils in number, and in most cases coeducational. The curriculum usually embraces the following basic objectives:

1. To develop sensory and motor skills.
2. To develop basic concepts of self, other persons and the general environment.
3. To develop basic skills of communication.
4. To develop self help skills, such as dressing oneself, feeding oneself, bathing, etc.
5. To develop social skills.
6. To develop limited academic skills - such as reading danger signs, socially protective signs, etc. and to learn simple arithmetic concepts and usage such as involved in handling money, and simple estimates of weights, size, etc.
7. To develop vocational skills as might be required in sheltered employment and/or domestic life.
8. To develop an appreciation for music, art, etc.
9. To develop physically through planned physical education activities.

It is readily seen from the above listing of program objectives that these are in many ways not unlike those set forth for educable pupils, indeed pupils of normal intelligence. The basic difference is one of method and expected level of proficiency.

We have not carried on this type of program for trainable for a long enough period of time to evaluate accurately the effectiveness of our programing. This is mainly the cause for our delay in adopting a uniform program, hoping that at such time as uniform programing becomes the order of the day, we will be able to plan this with good insight into what type of program works, and what type does not.

In terms of a general statement regarding programing for trainable pupils on the whole, it seems that one major requirement for successful programing and planning is for the most part unmet and needs immediate

attention. This is the requirement of longitudinal planning, i.e., planning education and training services which extend from the very young trainable to adult trainable with logical sequence and with very definite goals or objectives leading to a useful life for the trainable pupil when he no longer is in school. This involves not only educational programing, but total community programing. There is not much merit and certainly little sense of achievement on the part of the pupil and teacher alike if the education program leads to a blank wall of vocational and social participation upon graduation or dismissal from school. While there has been much progress in this area of concern through sheltered workshop programing, these efforts are far and few between, and may rest on very shaky financial foundations. This seems to be the next great frontier to conquer in training and education and rehabilitation programing.

It was stated previously that training and education services have been extended principally to trainable and educable pupils, and more precisely to those in these categories who are of school age.

It is our hope that future programing will include at least three additional areas of service.

The first of these is preschool programing for the very young retarded children. Recent research done elsewhere supports the need for such services, but is undecided on the content of this level programing. Inasmuch as the period of development under age 6 is so critical to ultimate functioning, intellectual, social, etc., there is ample reason to believe that much more attention should be given to this aspect of education and training programing.

The second new area of service to be more thoroughly explored is that of the severely retarded. This group comprises a vast number of persons within our residential schools. A special project carried on some years ago at one of our schools involved teaching severely retarded to feed themselves and was highly successful. Unfortunately a limited number of staff forced the discontinuance of this program. We did learn, however, that these children profited from training and this needs to be explored further and implemented as part of the total training and education service.

The third area of new service, which is being provided to a limited extent at present, is the need for adult education classes. These classes aside from providing extended formal education opportunity, should serve mainly to prevent regression in academic skills once the pupil has left the academic school setting. Typically many pupils will have achieved a good functional level of academic skill at the time of graduation. However during the period of time between graduation and vocational placement wherein these skills are required, we often see a regression of academic skill to a nonfunctional level.

RESEARCH

Research projects are being carried on in a number of different areas of programing. Even so the amount of research is limited, and there is a continuing need for increased effort in this direction. Some of the current research projects are:

1. An analysis of 131 jobs deemed suitable for mentally retarded and suggested pre-vocational and vocational curriculum.
2. Curriculum and program development for trainable pupils.

3. Gross motor skills of Negro retarded children. (A comparative study with normal Negro children)
4. Reading achievement level and its relationship to general performance and adjustment by pupils in special classes.
5. Development and standardization of pupil progress evaluation questionnaires for educable pupils at all levels of academic school programing.

In conclusion, a few words need to be said about cooperative programs of training and research preparing professional workers in the field of mental retardation. A brief look at training programs, particularly at the graduate level, available to teachers, administrators, and others, in mental retardation at our North Carolina colleges and universities is somewhat discouraging. Whereas there seems to be well organized summer programs at certain of our colleges, little is offered in terms of full-time programs leading to higher degrees.

We who work in the field are acutely aware that programing for retarded is becoming such a complex process that the few basic courses now offered are woefully inadequate insofar as they prepare the professional worker to understand and contribute adequately to this field of specialty.

There is no simple solution to this problem, but it does seem apparent that certain agencies have responsibility to make some positive step in the direction of providing better training for teachers and others working in the field of mental retardation. We can identify at least two responsible agencies - universities and colleges, and those agencies which extend direct service to the pupil.

It has been said that the greatest deterrent to university action is the lack of students seeking such training. However, it is reasonable to assume that students won't seek that which does not exist.

Someone must make the first step, and it seems that universities and colleges need to assume this responsibility.

On the other hand, those agencies directly serving the pupil, and employing the graduate trained to work with retarded, need to lend their full support and assistance to university and college programing. For example, the Training and Education Departments within our state residential schools could be utilized for teacher training, and controlled research in curriculum, and general educational problems of retarded. Indeed we are one of the few progressive states where this is not being done as a cooperative venture between university and residential schools.

Let us hope that failure to achieve these goals is not based on a lack of interest and concern by those involved. Surely it is well recognized that much is to be gained in the general understanding and betterment of all mankind through such programs of cooperative research and training. Finally, we need to remind ourselves that wherever men shall extend the parameters of their interest and thinking, therein new perspectives and insights into the unique value of all men shall be gained, as well as the universe in which he lives.

3:30 p.m. Wednesday -- The response and discussion led by Doctor Nisonger had as its focus the problem of identification and diagnosis. Retardates are so frequently not discovered until school age. The various intricacies of this question were reviewed. There is a need for expanding child study services, pre-school evaluations, and periodic re-evaluations. If it is true that much retardation is due to a lack of stimulation because of psycho-social deficiencies, then we ought to find ways of identifying retardates earlier; but there is at present little machinery to discover retardation in the pre-school years. Maternal and child health services, well baby clinics, and private physicians pick up some; but diagnosis and identification are not organized on a community basis.

It was pointed out the criteria for retardation in the pre-school years are different and are largely dependent on medical (e.g., neurologic) deficiencies. In the school years the criteria are educational. They change again for the adult years when they are essentially behavioral or social criteria. During the school years the problem of retardation stands out most prominently and tends to diminish later.

The need for psychologic assessment, refined and including overall measurements, was stressed. Too much reliance on objective tests like the I. Q. is unwise. There is a great need for adequate measurement of general adjustment (social, psychologic, vocational, etc.). At present this measurement is best done by clinical evaluation considering all aspects of the individual's life in a genetic and dynamic appraisal. Parents often fail to use available evaluation resources for emotional reasons which might be dealt with by better public education.

9:00 a.m. Thursday -- This day was planned to be devoted to problems of education of professional personnel in the subject of mental retardation. Realizing all professional groups could not be represented on the panel, we simply chose a few who are vitally involved or are in positions qualifying them to speak to this issue.

Doctor Harrie Chamberlin, Associate Professor of Pediatrics of the UNC School of Medicine Department of Pediatrics, agreed to be moderator for the morning panel which we inclined toward the medical professional education problem. Doctor Chamberlin is particularly qualified to help us in our examination of this matter; interested in pediatric neurology and experienced in the clinical and most practical aspects of the handicapped, he offers a perspective, both academically and practicably sound. He, therefore, was effective in stimulating discussion and contributing to it.

Doctor Harris, Professor of Pediatrics and Chairman of the Department of Pediatrics at Duke University School of Medicine, led off the panel discussion with his paper on the education of medical students and graduate physicians in mental retardation. Doctor Vernon gave views from the psychiatrist educator's vantage point.

Miss Elsie Ho, Nurse Consultant of NIMH, then presented her paper on nursing education in this field.

# TRAINING PROGRAMS FOR MEDICAL STUDENTS AND PEDIATRIC RESIDENTS IN THE AREA OF MENTAL SUBNORMALITY

by

Jerome S. Harris, M. D.

Before discussing details concerning the training of pediatricians and physicians, perhaps we should emphasize the importance of stimulation of interest, curiosity, and enthusiasm in the area of mental retardation. The interested and enthusiastic physician is in a better position to take care of these problems as he meets them in practice. Perhaps some students may be stimulated to specialize and do research in this field--research which is so needed at the present time.

Recognition, early in a medical career, of the importance of these conditions is a potent stimulus to interest. I doubt whether it is well known among students, or even among residents and physicians, that approximately 150,000 mentally subnormal individuals are born yearly in the United States. Enthusiasm can also be generated by positive and encouraging attitudes. Instead of dismissing mental deficiency as a hopeless problem, it should be emphasized that there are many different causes of mental subnormality, that some of the forms may be prevented, and that other forms are amenable to therapy. Medical personnel should be aware that there are genetic, prenatal, paranatal, and postnatal causes and that the physician has a responsibility, not only in diagnosis and therapy of the afflicted child, but also in early recognition of possible etiological factors so that preventive measures may be employed. Hope for the future may be instilled by pointing to past accomplishments

and the increasing number of types of mental subnormality which now can either be prevented or cured.

Having (hopefully) stimulated interest, we may now ask, "What are the objectives of our training program?" These include training in early recognition, diagnosis (particularly differential diagnosis), specific therapy, and comprehensive management of the mentally defective child when specific curative measures are not available. In addition to diagnosis as to etiological factors, type and function, it is most important to understand some of the conditions which may mimic mental subnormality. I am always reminded in this regard by the fact that approximately one-third of patients who come to our anti-convulsive clinic have non-convulsive disorders (particularly behavior disturbances) which should be treated by means other than anti-convulsive therapy. I believe a similar situation probably would hold true if one were to carefully screen, diagnose, and study all factors in the individual patient who appears mentally retarded. Many of these children would turn out not to be truly mentally defective but rather to have some other difficulty which limits performance but does not necessarily diminish ultimate capability. Such conditions include delay in maturation, social and emotional disorders, physical handicaps in vision, hearing, or motor ability, psychiatric states, and perhaps continual epileptic discharges. Attention to these factors may give one the satisfaction of seeing marked improvement in what might otherwise have been a hopeless situation.

Early recognition, particularly where specific therapy is available, is another area which requires emphasis in a training program. Certain

diseases, such as meningitis, lead poisoning, etc., can cause mental deficiency which, however, may be prevented by early recognition and rapid therapy of the underlying disease. Other conditions have specific forms of therapy which must be applied very early in life. The physician should be able to recognize the diseases in the early stages. Thyroid dysfunction in infancy and several of the so-called molecular diseases due to enzymatic defects fall into this category.

Having made the diagnosis, having tried to do what one could do to prevent the disease, to treat it, to recognize other factors which are not strictly defects in mentality, it then becomes necessary to institute (and teach) a rather comprehensive management of the mentally defective child. In the training program, the focus should be family centered rather than on the individual child because the problem, as undoubtedly will be taken up later, involves the entire family. There are many facets here that require attention - the relationship of the parents and their child, the type of home, whether institutional care or home care is preferable, how much can be done with home care. In order to do this, the physician has to receive training in family inter-relationships and in the nature of the community and state resources.

Finally, I believe a training program should so stimulate students that some will enter into the field as a specialty either to staff the various hospitals and state resources for these conditions or to do research which will advance our knowledge and therapy in this area.

How can one accomplish these objectives? As far as undergraduate medical students are concerned, the prime requisite is exposure to an enthusiastic knowledgeable senior staff who can stimulate the student

to think more about the problems which are involved. This can be done throughout medical school. Even in the preclinical subjects, one can emphasize factors leading to mental deficiency; knowledge of enzyme-defect diseases could be taught in biochemistry, immunologic factors that are involved in erythroblastosis are part of microbiology. Additional material pertinent to problems of medical deficiency could be included also in clinical subjects, particularly in pediatrics and obstetrics.

Many schools have tried family care programs and the assignment of students, perhaps at more advanced levels, to families with a retarded child so that they can see the problems at first hand and become sufficiently interested to determine the nature and extent of community and state resources. In this manner they might later be able to recognize deficiencies in their own communities and take the lead in the establishment of proper facilities.

As far as the intern-resident training program is concerned, we are very much interested in integrating teaching in this area with facilities that are available in the state. For maximal effectiveness, these facilities should be located in fairly close proximity to teaching institutions. It seems rather pointless to waste the material, the facilities, and the training potential of the state mental institutions by placing them in isolated areas so that they tend to degenerate into custodial care units. Following the lead of the Veterans' Administration, many states are taking the wise move of constructing their hospitals near teaching institutions. It is fortunate that the Murdoch Training School is sufficiently close to both Duke University and the University

of North Carolina as to make feasible the establishment of joint training programs. Parenthetically, I have often wished that North Carolina would buy a large tract of land halfway between Chapel Hill and Durham to allow construction of additional units in this location in the future.

One great advantage in the proximity of state institutions to universities lies in the ability to attract capable and enthusiastic medical personnel to staff the institutions. These young men are interested in the academic affiliations which could be insured by joint appointments in the state institution and in the medical school. They would realize the intellectual stimulation that comes from teaching medical students and residents. Further, research programs could be entered upon with the cooperation of both institutions and the facilities and skills within the medical schools could be utilized fully for this purpose. Combined teaching programs could be arranged which would include complimentary and mutually beneficial phases in the two locations.

I do not know how many of you come from North Carolina, but I would like to mention how cooperation between the Murdoch Training School and the two neighboring universities is developing. The training school will have a diagnostic center which will demonstrate to students and residents the importance and nature of a complete evaluation of the child suspected of being mentally subnormal - emphasizing the need for a thorough understanding of all factors which may prevent both normal and defective children from reaching their full potentiality. Doctor Chamberlin has been taking student groups

frequently to the training school and has been stimulating them, I am sure, by his enthusiasm and by letting them see at first-hand the total problem of mental deficiency.

In addition to the Director of the Diagnostic Center, Murdoch School also will have a Director of Training and Research together with many supporting medical personnel. Many of these will have university appointments in the two medical schools. It will then become possible to rotate pediatric residents to the center and have them stay for a period of time, much as they would rotate through various divisions of a pediatric service. By observation under guidance for perhaps a month or two, by being constantly exposed to the various problems, and by close contact with the two directors, these young pediatricians will become more knowledgeable in the total management of problems related to mental subnormality. It is hoped that the training school will have an active research program so that these young physicians will become aware of the need for additional intensive research. Perhaps some of them may be encouraged to undertake problems of their own - ultimately to become investigators in the area of medicine.

These types of training, both at the student and at the postgraduate level, should be effective in giving better care to the patients themselves, in producing trained individuals to become leaders in their community, and in enticing capable personnel to enter upon careers of teaching and research in the general area of mental subnormality.

# EDUCATION OF MEDICAL STUDENTS AND PSYCHIATRIC RESIDENTS IN THE SUBJECT OF MENTAL RETARDATION

by

Charles R. Vernon, M. D.

I. I speak to you as a representative first from a medical school faculty and second a psychiatric residency training faculty. I should like to pursue the question of education on the subject of mental retardation in these two training categories, that is, for medical students and for psychiatric residents.

With respect to medical students, a basic issue needs to be kept in mind constantly. That is the matter of presenting to the student a consistent picture of medicine as a whole, as opposed to the piecemeal view of categories of people, or organ systems, or disease syndromes. Students conveniently isolate from their thinking problems which are anxiety provoking in their social and psychologic implication unless their teachers are facing and dealing with these problems. Mental retardation falls into this class in the same way that all mental illness used to. If we, as teachers, reveal our fears by a denial of mental retardation as a medical problem, explicitly or implicitly, students will stand clear of it as well. There are plenty of hopeless medical situations in which the students' interest is easily illicited because his teachers are actively interested. Examples are cancer and blood diseases. It is with the chronic problems which involve poorly defined concrete disturbances and whose organic dysfunction is difficult or impossible to detect that avoidance reactions come into operation.

II. What is our task? First is the dissemination of the knowledge itself - getting across the facts about mental retardation. There are several ideal places for these matters to be considered: neuropathology, neurophysiology, and biochemistry in the basic sciences; obstetrics, pediatrics, neurology, and psychiatry in the clinical disciplines. For medical students in general the best setting for material to be taught and get it to stick is in the clinical situation. From a clinical standpoint the most enthusiastic teacher for medical students would be the pediatrician because he gets faced with the matter in his practice so much. It is my feeling that here is the place where much of the material can be most effectively introduced, that is, in the setting of practical clinical medicine as the doctor sees the patient, not in the highly specialized clinic. This is not to imply that the specialized clinic is not a valuable teaching experience.

The institutions for the mentally retarded, of course, present the best concentrated source of case material, a truly specialized clinical situation. Here there is dramatic impact and a wealth of clinical material. What is lacking usually is the teacher. The so-called training schools are virtual neurologic institutes, as well as psychiatric ones. We must turn them into training institutions for professional groups as well as service institutions. I regard this as crucial for the mentally retarded, whose neurologic or psychiatric problems render them unable to live in society and be taken care of by the local community. Their utilization by medical schools is a necessary step in this direction.

III. For the psychiatric resident, the answer is similar. The clinical setting represents the best place for his learning the facts about mental retardation and how best to give service. However, I should think it would be of particular advantage for the resident physician to get experience in the screening and diagnostic centers, to be acquainted and impressed with the problems at the community level, so that as a practitioner he can better serve in his community as part of the team (nurse, social worker, teacher, pediatrician) that will deal with this problem. Maximum reliance on community resources without over-burdening them is a logical and hopefully realistic course.

IV. In large measure dealing with the mentally retarded turns out to rest less soundly on a base of scientific knowledge than on common sense. In the final analysis a retarded child can do what he can do. We do not really know until we give him a chance. Esoteric examinations give guidelines but rarely give as much as an overall clinical view of the person interacting with his environment. So, with this assumption, it follows logically that practical experience will be the best basis for training in this area for the future physician or specialist.

# EDUCATION OF PROFESSIONAL GROUPS IN MENTAL RETARDATION - NURSING

by

Elsie Ho, R. N.

In the education of nurses, considerable efforts are being directed towards developing teamwork skills requiring motivation, training, and experience.

On the matter of motivation, we see nurses becoming more active participants as members of the multidisciplinary team. This is a concept new to many professional nurses. Various approaches have been developed by agencies and institutions to put across the message that nurses need to know the philosophy and program objectives of the institution. In institutions, nurses need to know something about each child which calls for sharpening of observation skills and getting an understanding of what it means to develop whatever potential there may be to the utmost. Nurses need to know in order to interpret.[1]

Studies and staff conferences are techniques used by many for communicating the philosophy or orientation as to what program administrators hope to see reflected in the prevention of mental retardation, care and treatment and rehabilitation of the mentally retarded. In an article,[2] "Need for Improved Criteria in Evaluating Job Performance of State Hospital Employees" by A. M. Shotwell, H. F. Dingman, G. Tarjan, mention is made of the importance for members of the nursing staff to look at their jobs and define their roles in the treatment program. Since the bulk of nursing staff in mental retardation institutions consist of psychiatric technicians or attendants, there is need to

define what is the technician's job. The article mentioned describes a psychiatric technician's job as one requiring him to consider patients' welfare as well as be a good housekeeper and manager and one who cooperates with his fellow workers and other employees. I believe it is important that institutions have a clear statement of their expectations in order to effectively orient workers--new and old. Supervisors need to be clear on this role because they will pass their thinking along to technicians and others.

Yesterday, we talked about the change in emphasis from custodial care to therapeutic, constructive handling of patients. We need to expand and extend training programs to discuss current problems or aspects of the job. In the same article referred to earlier, mention is made of the relative importance which various types of employees attach to activities performed by psychiatric technicians. A study on relative importance which various types of hospital employees attach to activities performed by psychiatric technicians reveal:[2]

(1) Psychiatric technicians look at their job essentially the same way that supervisors do.
(2) Professional personnel look at technicians' job in a different manner.

Items supervisors and psychiatric technicians placed higher value than professional personnel:

1. Being neat and clean in personal appearance.
2. Being on time.
3. Keeping busy at making ward neat and clean.
4. Thoroughly understanding that the charge is boss of a ward.

Items supervisor and psychiatric technician placed lower value than professionals:

1. Being friendly to patients.
2. Calling charge's attendant to patients the psychiatric technician thinks are working too hard.

3. Initiating new ward activities for the pleasure and benefit of patients.
4. Liking to be with patients.
5. Playing simple games with handicapped patients.

To improve communication skills in nursing, workshop sessions are being sponsored by universities, schools of nursing, nursing organizations, health and welfare agencies, mental hospital departments, etc. An example of such efforts is described in an article in Project News, "Public Health Nurses Meet to Discuss Services to Mentally Retarded."[3]

I believe nurses are as busy as other professional groups in recognizing the need for staff development programs. Recently, a psychiatric nursing consultant on the state level completed the conduct of a series of in-service education sessions for graduates at the state mentally retarded institution. This came about as the result of a one-day workshop on "Interpersonal Relationships" held four months earlier at that institution. Many things were said at that initial conference to stir up feelings regarding the need for nurses to get together, look at themselves, the job to be done, and to get some kind of training going. The hospital administrator asked the psychiatric nursing consultant to do the job since she was a nurse specially trained in psychiatric nursing, skilled in teaching, and highly regarded by that graduate nursing staff. Over the years of consultation, this nursing consultant has demonstrated real leadership as a nurse educator and administrator in a practical and dynamic way. This kind of performance can do a lot to contribute towards building high morale and improved communication within any institution.

Another helpful resource to nurses is the National League for Nursing. This organization on the national level has in-service education

consultants available to assist in this area of concern. Their publication, Nursing Outlook, contains many articles yearly on the subject. Local groups called "Council on Psychiatric and Mental Health Nursing" are highly active in many states sponsoring educational meetings on communication and other staff development subjects planned by the local membership to improve the attitudes, the knowledge, the skills, and performance of nurses.

A report recently released on the subject is entitled, "Proceedings--Conference on Staff Development in Psychiatric Nursing," sponsored by the Western Council on Higher Education for Nursing, the "SREB" of the West.[4] I think you will find these proceedings supportive of the kinds of concerns you are faced within this state. Page 13 includes a write-up on "Improving Patient Care For the Mentally Retarded by In-service Programs." This conference brought together directors of nursing service in state mental hospitals and schools for the mentally retarded to discuss the content and conduct of staff development programs in their institutions.

North Carolina is rich with resources for the education of nurses. I believe every one of you represented here should be exposed to nursing education conferences and programs at one time or another. Nurses need to be included in conferences such as this to keep abreast of ongoing developments in the field of specialty and to prepare them for changing roles and responsibilities. Nurses need to know their community resources--the agencies, their functions, and the people in them to be successful co-workers. Nurses need training centers for learning and practice fields.

Yesterday, there was a plea for workshops or courses to be conducted for teachers of mentally retarded children in North Carolina, university based. It is my hope that such planning should include courses for nurses. Many nurses currently employed in institutions and agencies dealing with the mentally retarded in institutions and agencies dealing with the mentally retarded lack basic training in the specialty. Some universities offer regular workshops for teachers of mentally retarded as in Virginia.[5] There ought to be similar educational programs available to help nurses do a better job. The standard of nursing care in a given institution can be no better than the knowledge and abilities of the nurses. In some instances, nurses know less about the care of their patients than the attendants they are supposed to be supervising.[2]

There are other aspects of the nursing program which need careful and critical examination. I am thinking of items such as:

1. Daily work schedules and assignments.

   Do we know our nursing staff?
   What are their talents or abilities?
   Are we making the best use of our nurses?

2. How creative are nurses?

   How can we teach nursing staff to engage in constructive play activities? We are told that mental retardates develop through play.[6]

   Where do nurses learn to play?
   How can specialists like the recreational therapist, occupational therapist, group worker, etc. help?
   Where are these specialists?
   How can nurses be motivated to change?

3. What can we do to make our institutions more homelike?

   Some nurses are wearing colorful sportswear on duty.
   This type of clothing seems most appropriate in some settings.

Some nurses can accept this change; others not.
What use are we making of volunteers? of parents? of other community resources?

I believe we need to do something more in this area of change. Studies show that the mentally retarded seem to develop their potentials more in home settings where they receive individual attention and are able to enjoy community life than they do under institutional care.[6] How can this be accomplished or tried-out in your setting?

What kind of help do nurses need to identify areas and personnel to provide individual attention?

In all of this, I want to say that I feel encouraged about the changing role of nurses in mental retardation programs in evidence today. It is heartening to meet and hear administrators like Doctors Wortis and Anderson supporting the contribution of nurses. We need more demonstrations utilizing nurses like that being conducted in Doctor Wortis' hospital. We need to continue our efforts to help foster positive attitudes among nurses through the guidance and leadership of nurses such as we have here at this conference: Pediatric Nursing Consultant, Laura Harbison; Nurse Faculty Members, Barbara Bernard, Louise Contrell, Evangeline Poulos, Julia Smith, Margaret Brown; Nursing Service Administrators, Mrs. Rogers, Mrs. Kincaid, Miss Booth, etc. We need to have more nurses like these to extend and expand our nursing education program to reach all nurses currently in training and on the job, for nurses represent a large group of citizens and function as important health educators.

May I wish you success in the follow-up steps to be taken at the close of this conference. It's been a pleasure to meet with you; to talk about past endeavors, hopes, and the necessary next steps.

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Thursday Morning Discussion -- Many points covered in the papers were brought up and discussed. Emphasis was placed on the need to put what we already know into action. Education institutions where professional groups are trained tend not to be aware of the immense problem to society posed by mental retardation. Their attention must be obtained. Apparently many teachers in professional schools shy away from the field because of their own ignorance of it. It was suggested that more graduate courses be held for physicians and nurses who have to deal with retardates. Institutes might be organized at Murdoch School, maybe under the auspices of, or co-sponsored by, one of the universities. The responsibility of the university to involve itself in this field in all appropriate departments from both research and training standpoints was reiterated. Here again the idea was proposed that the institutions for the mentally retarded be transformed into research and training centers, perhaps with the name, child development centers. The community clinics and other agencies can be training and research centers, too.

Cultural prejudices were reviewed, especially their importance in fostering the exclusion of retardation in our thinking. High value is put on "intelligence" and the word becomes diluted simply to mean academic proficiency.

Emphasis should be on not excluding the mental retardation problem from our thinking. It is not so much that this area should be given special attention as it is to give it equal attention or appropriate attention.

2:00 p.m. Thursday - Doctor Harvey Smith, a professor of sociology at UNC and experienced in the study of medical problems, moderated the Thursday afternoon panel. Doctor Smith is one academician who has put his erudition to work in the field. Some of his graduate students, for example, have worked and studied in the mentally retarded institutions. These residential centers have invited further use of their facilities for basic science research, as well as clinical investigation.

The first presentation was given by Doctor Rue Cromwell, a clinical psychologist who heads up a graduate program at Peabody College specializing in mental retardation. Doctor Cromwell has taken interest in the study of mental retardation,and his graduate program is unique in this section of the country. Clinical psychology as a discipline has a great deal to contribute to the solution of problems of mental retardation. As a basic science, it also has a great deal to learn from mental retardation.

Mr. Julian Hanlon, psychiatric social worker and acting director of the mental health section of community health services branch of NIMH Region III, presented his view, which is particularly valuable because of his knowledge of this region of the country with regard to mental health facilities.

Finally, Doctor Roy Sommerfeld, from the School of Education at UNC, outlined perspectives regarding teacher training from the educator's standpoint.

# TRAINING OF PSYCHOLOGISTS IN MENTAL RETARDATION
(with the use of slides and handouts)

by

Rue L. Cromwell, Ph. D.

In talking about the training of psychologists for the area of mental retardation, I will spend a good deal of time today talking about the mental deficiency training program in psychology at Peabody College, which is a total emphasis program. Then I will try to extrapolate from that some of the things which would be important in teaching psychologists about the area of mental retardation in any graduate department around the country.

As some of you know, around 1953 the National Institute of Mental Health made a grant to Peabody College, approximately $123,000, for training ten Ph. D.'s with special emphasis on research training in the field of mental retardation. This grant came because of the recognition of the vast amount of neglect toward the area of mental retardation in psychology, as well as in other professions. It was hoped that by having a total emphasis program of this type, something could be accomplished in the way of making a dent in the kind of research knowledge which was needed in this area. Since that time, there have been a number of extensions of the program.

One of the reservations that any psychologist or any professional person might have in a total emphasis program, such as in mental retardation or something else, would be that the emphasis might weaken the basic training in psychology or in the person's own profession. This kind of

problem was neatly avoided at the very beginning in the program at Peabody by putting the mental retardation training in the minor area.

Peabody has a major-minor program. Our students major in psychology and minor in some other field. The students with mental retardation fellowships all minor in special education with courses primarily or only in the area of mental retardation. In the major, then the students can choose one of two alternatives. They can choose a straight experimental psychology major. Or, they can choose the clinical psychology training program. This, again, has a basic research orientation but does give all of the clinical training which clinical psychologists get. Research is handled through research teams which meet weekly with the major professors. Here they argue through various problems of the experimental design, theory, etc.

The program has been successful, greatly because of the cooperation with the local state facility, Clover Bottom Home (more recently Clover Bottom Hospital and School). There has been a great deal of research on various levels, from basic to applied research, which has taken place at this facility, as well as in the special classes around the Nashville area and also in institutions and public school facilities in the neighboring states. Just before I came to the conference, permission was granted by the state to start working on a $30,000 research building, specifically for psychological research in the areas that are being advanced at Peabody. So this, I guess, speaks more than anything else about the kind of cooperation between Peabody College and the state facility.

In the minor area there is the first-year sequence (see Table 1): an introductory course in mental retardation, a course on education of the mentally retarded which focuses toward the learning and teaching problems which special classes and institutions have with the mentally retarded. Then comes student teaching or field work in mental retardation. This, of course, although sometimes looked on as a bitter pill by psychologists, affords a face-to-face contact with retarded children which they could not get in a more structured setting involving experimental research or straight clinical diagnostic work. It is a profitable experience.

The second-year level is what we call the mental deficiency seminar, a year-long sequence. The first seminar is conducted with the Vanderbilt School of Medicine and the Department of Biology at Peabody. Here we contract a different lecture for each seminar night. The cooperation and closeness of relations is superb. Usually, the heads of the departments in pediatrics, obstetrics, etc., are the ones who give the presentations on mental retardation as it is viewed by their particular specialty. (See Table 2) Our students get a fairly intimate knowledge of how the physician thinks diagnostically and how he goes about his problem-solving process with regard to the various aspects and etiologies in the area of mental retardation.

Then the next course--psychological aspects of mental deficiency--go into basic learning, sensory and perception processes, and the basic research knowledge which is known already in the area of mental retardation (a sort of thing which is typically not a part of graduate programs, of course). Also included are the more applied topics of psychotherapy,

psychometric work, organic brain damage, etc. (The syllabus of this course is illustrated in Appendix A.)

Then comes the third course which is called the sociological and educational aspects of mental retardation. (This course, illustrated in Appendix B, handles such topics as epidemiology, day school movement, various social and educational studies, etc.)

In each one of the seminars, we have a nationally known consultant come to talk about his particular area. In the medical seminar, for example, we have had such people as Dick Masland, Herman Yannet, and George Jervis. Also included is a Clover Bottom clinical demonstration. The staff there, physicians and psychologists and social workers, present a day and a half clinical demonstration of the various types of common and rare diagnostic classes of mental deficiency. In these various ways the students become well exposed to the medical aspects of the problem. This gives a basis for being able to communicate and colloborate with medical people on basic research problems.

Both the clinical and experimental fellowship students are required to take internships. The de-emphasis around the country among clinical psychologists in various training programs on the retarded individual makes the internship a difficult thing to plan. As a result, we have to handmake or put together a number of internships where individuals can work with an outstanding researcher in a particular university setting and have the other half of his internship with a competent clinical psychological staff in an institution or clinic. For example, we have worked out such combinations as D. O. Hebb and the Montreal Children's Hospital; Neil Miller at Yale, together with Southbury Training School;

Don Lindsley in EEG research and Pacific State Hospital; Rotter at Ohio State and Columbus State School, etc. We have been very fortunate in getting this kind of cooperation around the country.

Now, a brief word about the kind of research being trained at Peabody. (See Table 3) One can get the major gist of it by reading the journal articles which come out of the research program. By and large, the major areas of concentration are on basic learning process, hyperactivity in a retarded child, personality variables involving response to success and failure, evaluation of the classroom learning process, etc.

With this summary of a "total push" program which emphasizes research in mental retardation, we can now ask the question, "What should be included in the typical graduate programs in psychology which are not now included?" The first suggestion would be to include the basic knowledge about mental retardation in a course by itself or in a major part of a core clinical course. During this period of time when there has been a great deal of neglect of mental retardation, some people have asked, "What is there to say about mental retardation that could fill up one whole course, let alone a whole year's seminar sequence?" The truth of the matter is that the MR fellowship program at Peabody has the whole minor program well packed with factual content about mental retardation, and has some of the stiffest courses in the graduate program. But what is good for everyone? I believe most anyone would agree this is too much for the typical clinical psychology training program. I had, on the other hand, two lectures on mental retardation while I was getting my Ph. D. work, and I understand that this inadequate preparation is about par for the course across the country. (In Appendix C is a

syllabus which serves to exemplify the type of material which could represent a more thorough exposure to the problems of mental retardation.)

The second suggestion would be that the clinical demonstration of mental retardation cases would be of value in all clinical training programs in psychology. With such a demonstration, students would have the opportunity to visit a state institution or facility and hear a formal presentation of the medical, psychological, and social aspects of various types of cases there.

The third suggestion would be to include a greater amount of contact with retarded children in the regular clinical work. Sometimes in some training programs mental retardation is rejected as being less interesting than emotional disturbances in children. It is felt that the psychodynamic picture is less interesting in the latter case. Actually, I do not believe this is true. When one takes the total problem of a mentally retarded child and his family, the psychodynamics involved are most challenging. The social dynamics with regard to how the parents can conceptualize the child and how one should work with regard to helping them to change in their feelings and conceptualization about the child in a way of the most optimal benefit to the child are aspects which are most exciting. They are as interesting as any aspect of clinical psychology work.

The fourth comment is that cooperation which researchers typically can get in state schools presents a welcome and efficient research training situation. (I understand such is true in this state as well.) This seems true not only for clinical psychology but also for experimental psychology. Therefore, I feel that professors and students interested

in basic experimental psychology should be made more aware of the opportunity for research in state schools for retarded.

## SUMMARY

In summary, why should the training of psychologists for mental retardation be of particular interest? First, more and more services for mental retardation are coming to be geared toward a psychoeducational and habilitative approach as well as an etiological treatment approach on a medical level. Thus, the psychologist has a unique contribution here, as a clinician and as a researcher, in behavioral, intelligence, and ability analysis. Second, since intelligence, a behavioral construct, remains as the core of the definition of mental retardation and, physiologically, the etiologies occur on many different levels of discourse, the need for interdisciplinary research, involving biochemistry, physiology, sociology, psychology, etc., is of utmost importance. The psychologist should be prepared to communicate and colloborate in such interdisciplinary research. In this paper, a "total emphasis" program to prepare psychologists for these roles in mental retardation was described. Then, a number of suggestions were made concerning what would be important for the basic training exposure to mental retardation in any clinical psychology training program.

Table 1

MINOR CURRICULUM IN MENTAL DEFICIENCY

Introduction to Mental Retardation
Education of the Mentally Retarded
Student Teaching or Field Work in Mental Retardation

Medical Aspects of Mental Deficiency
Psychological Aspects of Mental Deficiency
Social Aspects of Mental Deficiency

Table 2

MEDICAL ASPECTS OF MENTAL DEFICIENCY SEMINAR

Basic Anatomy and Physiology of Central Nervous System
Blood Incompatibilities
Seizures
Infections

Clover Bottom Clinical Demonstrations

Neurological Diagnosis
Electroencephalography
Neurosurgery
Metabolic Disorders
Drug Treatments
Endocrine Disorders
Toxic Conditions
Irradiation
Birth Injury

A National Consultant

Anoxia and Irradiation Research
Nutritional Research
Cerebral Palsy

Table 3

RESEARCH AREAS IN PEABODY MENTAL DEFICIENCY PROGRAM

Basic learning process
Basic personality process (Reactions to success and failure)
Activity level
Reaction time
Selection of ward personnel
Delayed reaction
Concept learning
Rhythmic discrimination
Projective technique
Day class training for trainable mentally retarded
Peabody Picture Vocabulary Test
Eyelid conditioning
Standard, "potential," and "altitude" I. Q.'s
Methods for teaching severely retarded
Attitude measurement and modification in attendants
Perceptual reversal rate
Response competition
Interpeduncular nucleus and retention
Molar variability
Prenatal effects of iproniazid
Semantic similarity judgments
Effect of drugs on behavior
WISC factor structure
Social attitudes toward retarded
Embedded figures test
Associative clustering in word recall
EEG alpha correlates

## Appendix A

### Seminar Topics

### PSYCHOLOGICAL ASPECTS OF MENTAL RETARDATION

I. Methodology

(definitions, research designs, molar versus molecular, confounding variables, statistical treatments, sampling)

II. Factors influencing intelligence

(Constancy of I. Q., environmental, cultural, and special training techniques, genetics)

III. Drug, vitamin, and chemical effects upon behavior and intelligence

IV. Therapy (other than 3)

V. Effects of brain-injury and other "retarding conditions" upon intelligence (scatter and profile, and related phenomena on I. Q. tests of various etiological groups)

VI. Tests for the detection of brain-injury in retarded

VII. Personality test findings

(Scales of anxiety, frustration, etc., Rorschach, Tat, Blacky, Zondi, and others)

VIII. Psychosis and other behavior disorders

IX. Sensory processes

X. Perception

XI. Motor skills

XII. Emotion and autonomic activity

XIII. Motivation, reward, and activity level

XIV. Verbal and maze learning

XV. Discrimination learning and learning set

XVI. Other types of learning: perceptual-motor, classical conditioning, operant behavior

XVII. Concept formation, abstract and concrete behavior, delayed reaction, stimulus generalization, and related concepts

XVIII. Theories relevant to defectives' behavior:

Cortical satiation, inhibition, Strauss, et. al. attention value, Hebb, other

XIX. Language behavior

## Appendix B

### Seminar Topics in Educational and Sociological Aspects of Mental Retardation

1. Introductory session

2. Classifications
   1. Sociological classification
   2. Educational classification
   3. APA and AAMD classifications

3. Epidemiological studies
   1. Lewis study (1926)
   2. Onondaga County (NY) study
   3. Illinois study
   4. Wishik study
   5. Intelligence test scores
   6. Prevalence estimates
   7. Future changes in prevalence and types

4. The residential school movement
   1. History and present status
   2. Cottage vs. dormitory
   3. Colonies
   4. The future

5. The day school movement
   1. History and present status
   2. Curricular changes (emr)
   3. Types of school provisions

6. Speech and language of the mentally retarded
   1. Language development of the retarded
   2. Speech correction for the mentally retarded
   3. The Kirk-Sievers-McCarthy language development scale

7. Sociological studies
   1. Farber family integration study
   2. Dr. Mary Hobbs study
   3. Quay-Bartlett study

8. Sterilization and mental deficiency
   1. Value and fact issues
   2. Status of sterilization in the U. S. A.
   3. Views of authorities
   4. Research on the subject

9. Eugenic considerations
   1. Fertility of the mentally retarded
   2. Inheritance of mental retardation
   3. Eugenics counseling

10. Educational research with the educable mentally retarded
   1. Sociometric studies (Johnson, etc.)
   2. Language arts studies
   3. Arithmetic studies
   4. Pre-school studies (Kirk, Fouracre)
   5. The brain-injured (Lehtinen, Jolles, Gallagher, etc.)
   6. Research in progress

11. Research with the educable mentally retarded (continued)

12. Community adjustment of the adult retardate
   1. Vocational rehabilitation
   2. Follow-up studies (Baller, Charles, Fairbanks, Kennedy, etc.)
   3. Goldstein's study
   4. Porter-Milazzo study
   5. Delp-Saenger study

13. Services for the trainable mentally retarded
   1. Types of school provisions
   2. Curricular issues
   3. Illinois, Michigan, Tennessee, New York studies
   4. The Cain-California study
   5. O'Connor and Tizard studies
   6. Sheltered workshops
   7. Home counseling services

14. Crime and delinquency
   1. Early studies (Dukes and Kallikak)
   2. Glueck studies and others
   3. Present status

15. The Retarded in Europe
   1. United Kingdom
   2. Netherlands
   3. France
   4. Italy

16. The family of the retarded
   1. Parent movement
   2. Parent counseling

17. Current events in mental retardation
    1. Agencies
    2. Associations
    3. Funds
    4. Legislation

18. Review session

19. Final examination

## Appendix C

### Introduction to Mental Retardation

Orientation
Definition of Mental Retardation
Distribution of Intelligence
Theoretical Nature of Intelligence (Three Lectures)
Nature of Diagnostic Constructs
Clinical Demonstrations of Types of Mental Deficiency at Local Institution
Psychological Nomenclature (Two Lectures)
Psychological Treatment Techniques (Four Lectures)
    1. Environmental Change
    2. Educational Approaches
    3. Psychotherapy, etc.
Medical Nomenclature (Eleven Lectures)
    1. Infection
    2. Intoxication
    3. Trauma
    4. Physical Agent
    5. Metabolism, Growth, or Nutrition
    6. New Growth
    7. Unknown prenatal influence
    8. Unknown cause with structural reaction manifest
    9. Unknown cause with functional reaction alone manifest
Sterilization
Criminality and Delinquency
Vocational Adjustment

# SOCIAL WORK EDUCATION AND THE NEEDS OF THE RETARDED

by

Julian G. Hanlon

During the past few years we have seen many changes and improvements in community planning of services for the retarded. Full credit must be given to the dedicated parent groups which have sparked what appears to be almost a revolution throughout this country. Certainly a conference such as we are now holding here in North Carolina is further evidence of this.

When the initial planning group met to consider the program for the retarded in North Carolina's state institutions it soon became obvious that lack of well-trained personnel was a serious problem. While this was a major concern of the Hospitals Board of Control, one of the sponsors of this meeting, it was also obvious that this concern was shared or should be shared by other agencies and groups in this state. The State Board of Health and the State Department of Welfare have a vital stake in what comes out of these deliberations. It is hoped that this conference, composed of people in programs for the retarded and educators in the various disciplines, will outline some next steps in a unified approach towards better care for this entire group of handicapped individuals, the retarded, and aid the growth of stronger educational programs for those having responsibility for this care.

It is well to be aware that while this nationwide concern to which I have referred in my opening remarks has resulted in considerable progress, much of this has been geographically spotty, or has been centered in

individual agencies. Too little attention has been paid to progress along a unified front.

As I travel around Region III and occasionally outside of it, two main themes about social service to the retarded seem to re-occur. From the agencies we hear that the schools of social work are not really training people for work with the retarded. Therefore, how can they (the agencies) hope to obtain qualified people for their community programs, out-patient clinics and their public and private institutions? They point to facilities for the retarded which have no social service programs at all. They point to institutions with limited social service staff, poorly trained, and generally incapable of exercising leadership.

The schools of social work, on the other hand, pose the question, "Where are the good programs which can be used for field work to tie in with class work? Where are the opportunities for exciting, stimulating experience for the new graduate? Are there enough local programs in Health Departments, in Maternal and Child Health Divisions, in Crippled Children's programs which view good social work staff as integral to a well-rounded program for retarded children? What do the large, custodial state institutions have to offer which can attract our graduates?"

Both of these positions remind me of the unanswerable question concerning the chicken and the egg. On the one hand, trained personnel is not available because the schools of social work feel no commitment to offer special training in this area, and the agencies use this fact to excuse their lack of qualified staff and worthwhile programs. On the other hand, schools are not training because there are no acceptable agency experience for their students, no forward-looking programs, and,

in effect, no real demand for good people, or so it might appear. Instead of spending my time attempting to reconcile these two positions, I would like to outline a few ideas which might point the way to a beginning solution and provide a jumping-off place for further discussion.

There can be no doubt that schools of social work are not training a great number of students ready and eager for positions in programs for the retarded. I surmise it is also true that in our schools of social work, students are given too little in the area of retardation and emerge from their training experience without a genuine understanding of the problem. Not enough serious effort is made to dispel the idea that the retarded are an unrewarding group to work with, incapable of using the skills of a social worker. A more hopeful philosophy is necessary which would develop students who see the needs of the retarded as not too different from the needs of other individuals; students who could attribute to the majority of retarded capacity to take and use help to a degree as great as the more intellectually endowed so-called "normal child."

Those interested in the retarded take the position that it is necessary to enrich the social work curriculum so that this new knowledge can be made available to students. It is well to point out that social work educators are hearing this same plea for enrichment and addition to the curriculum from the fields of probation and parole, juvenile delinquency, and many other segments of social work which feel that they are being slighted during the students' educational experience. Each group is dedicated to its own field of interest and presents compelling arguments for its own point of view. The embattled social work educators,

however, can legitimately take the position that there is a limit to the special programs which can be added to the two-year Master's Degree course. They also join with the medical school, the nursing school, and the departments of clinical psychology in pointing out that the student can handle and assimilate just so much in the regular period of study. Perhaps schools and agencies can give more thought to utilizing the third year of study for specialization in retardation for those students who may be contemplating a career in social work administration in the field or who may possibly envision a research career.

I have said, then, that we cannot ask the impossible of the School of Social Work. Nevertheless, we should be able to ask these schools to take a new look at what students are now getting in the area of care for the retarded. We ask whether this is adequate, sound, and if they are being given a valid picture of this field as a legitimate and rewarding place to work after graduation. There is no need to press schools to institute a whole new series of courses focused entirely on mental retardation. Existing courses in social casework, social services, child welfare, and community organization are the proper places where this enrichment can be effected. Our school faculties need to be certain that they are keeping abreast of the latest thinking in this rapidly changing and dynamic field. It should be possible for agencies and institutions to provide summer employment or sabbatical employment for faculty members to the mutual profit of both. Thus in addition to providing for education and stimulation of the faculty, we would also look to these individuals to make real contributions to practice in this field as well as valid additions to the social work literature and research.

There are many arguments against setting up a separate curriculum for individuals specializing in retardation. I remind you there are many social work programs not necessarily focused on the retarded individual where the practitioner has considerable concern for the retarded. Public Welfare and Child Welfare, the field of family welfare -- all of these provide service to retarded individuals and their families. As service to the retarded improves in these agencies, there will be less need for special programs and the retarded child will come into his own as a legitimate claimant to the same quality of service as all other citizens. Thus, the curriculum which ensures that all students gain a deeper appreciation for the needs and opportunities in retardation will be more far-reaching in its effect than a narrower type of education for one field alone.

This does not mean that we do not need good training centers where students may have field experience working directly with the retarded. I have not yet heard of a School of Social Work which was not interested in adding to the number of good field placements for its students. I feel certain that this holds true for placements in retarded settings as well. Schools of social work have been so interested in broadening their field work programs that in many instances they have been instrumental in initiating training in neglected fields. This has happened even to the extent where faculty members have been provided who served as agency supervisors and at the same time provided on-going program consultation. This may be true here in North Carolina also; but if not, it is certainly something to consider as a possibility for the future.

Sometimes agency people are a lot clearer as to what the trainers are not doing and what they should be doing; and they fail to see where their own responsibility lies. This leads me back to the role of the agency. If there is a sincere desire to improve social service to parents of retarded children in and out of institutions; to develop sound social services for the children whom we see in our institutions and clinics; to build meaningful foster placement programs and to prepare children for rehabilitation in a community setting, then there must be a conscious decision on the part of the agency to set up a valid social service department as a vital part of overall services to retarded children. There must be full recognition that social factors play a major role in the problem of the retarded child and in planning for his care. I make no claim that social factors are the sole province of social workers. Yet, this is an area of major functioning for the social work profession. Social service, then, must receive equal recognition in these programs for the retarded along with the medical, the psychiatric, the nursing care, the rehabilitation and education programs.

In too many places one sees social service departments concerned with the retarded, staffed by well-meaning college graduates or partially trained staff who laboriously follow an outline and come up with an informational type social history. This constitutes the major role of the social worker. They may also be seen making impromptu plans for return of the child to his community on a day-by-day, catch-as-catch-can basis. These are departments with a limited social work horizon, and they apparently satisfy the administrator whose horizon is similarly limited. In this indictment, I hope I may exempt present company.

My conception of a good program starts with the hiring of a competent chief social worker, able to serve the institution as a consultant on community organization, as one who can help bridge the gap between agency and community, and, finally, who can serve as a foundation and rallying point for a growing professional social service department staffed by trained and competent social workers.

I am neither naive or foolish enough to think that these departments can spring up overnight. The facts of life now dictate that we must assess the caliber of staff we now have and build the best program possible for us at this moment. We can call in our educators and our consultants to help us with the kind of staff development and in-service training program which will raise the level of performance for staff now on duty. We can provide opportunities for untrained staff to return for graduate training on agency stipends. We can see to it that at least one location in the state is available to serve as a training center approved by the School of Social Work where its students and staff may see a good program in operation.

Along with this must go an increase in the number of social work personnel assigned to programs for the retarded. Nor do we need to be discouraged by the fact that available social workers have not had their basic training and field work in the field of mental retardation. Recent trends in social work education now ensure a richer and more generalized basic training for all students. Where our programs offer the kind of leadership described above, it should be possible for the average, well-qualified graduate to move in a short time into a well-conceived program for the retarded, becoming an effective staff member after proper

orientation and continued opportunities for self-improvement on the job. Given this kind of commitment to good social service, there is no doubt in my mind that staff can be recruited and that developing programs will warrant the use of our institutions and facilities as training centers by schools of social work and by other training institutions as our fellow disciplines strengthen their own programs.

For purposes of this meeting I have focused somewhat narrowly on the field of retardation. Actually, everything that has been said applies to programs in all our public mental health facilities. More and more the spotlight is being focused on what happens to people when they go into public institutions. We have reason to believe that private institutions and local public units will be doing more for the retarded and the emotionally disturbed individual than has been done up until now. Despite this, and despite the fact that interest and concern for public institutions has a history of ups and downs, I question whether we will ever again be able to operate our public mental health services outside of the public view. The public institution under the impact of the Joint Commission Report will change radically, but it will not disappear.

It will come as no surprise to any of you when I say that I feel that there is a tremendous opportunity for the field of social work in the area of our concern today. I hope that this meeting will mark the beginning of improved programing for the retarded, and that through the meeting of minds that is taking place during this workshop better relationships will be developed between the training institutions and

the agencies which depend so vitally on the products of these training institutions. I feel certain that the end result of this conference on the retarded will redound to the benefit of all other troubled groups who seek help from their community agencies, both public and private.

# SPECIAL EDUCATION TRAINING PROGRAM

by

Roy E. Sommerfeld, Ph. D.

In the first place, I don't have a paper. In the second place, I don't presume to be a substitute for Leonard Magnifico. I'm here primarily at the suggestion of Doctor Vernon that the School of Education here at the University of North Carolina should be heard from. This is not to argue or even to respond to some of the comments that were made yesterday, but rather to take a look at some of the things that have been going on in the School of Education as far as the training of teachers in the area of special education is concerned. I report this only as an interested bystander; my training is not in special education. I've been teaching some of the basic courses which are required of teachers of special education. So, in reality, I guess I am more than an innocent bystander; I am an interested participant.

I cannot speak for the Dean of the School of Education, Doctor Arnold Perry, whose previous commitments have prevented his attendance here. What I have to say, then, will be colored by my own perceptions and does not necessarily represent the point of view of Dean Perry, or the School of Education.

One approach to this matter is to look at the certification requirements that the State Board of Education has set up for teachers of special education in the state of North Carolina. One of these requirements is that, first of all, the applicant for a certificate in the teaching of special education must have satisfied all of the requirements

for a teaching certificate, a regular Class A certificate. In addition to this, a minimum of 24 hours in special education is required. So, in effect, the program of special education becomes a graduate program. These 24 hours in addition to the regular professional requirements for teachers include certain constant basic requirements; such courses as "Introduction to Exceptional Children," "Tests and Measurements," "Psychology of Exceptional Children," "Mental Hygiene," and then specific course requirements in the area of crippled, speech correction, hard-of-hearing, visually handicapped, and mentally handicapped. In the area of mentally handicapped, they require a course in problems, materials, and methods of teaching; a seminar in mental deficiency; a course in arts and crafts; and a course in social treatment of feeble-minded.

We have in the School of Education catalogue courses which will satisfy practically all of these requirements. If the certification requirements are here, if the courses are available, what is the difficulty?

Essentially, there are two problems or maybe they are part of the same problem. One problem is staff, and the other problem is students. You do not get one without the other. When Doctor Vernon asked me to comment on this, I went back to the summer session office and checked the offerings which we had had during recent summer sessions. Essentially, this program in training of teachers for the mentally retarded is a summer session program. I checked the courses that were offered and the enrollments we had. (Actually, about ten years ago, there was an attempt to set up a training program for the teachers of handicapped

children. This was before I arrived, and the reports I have is that this program in effect died for lack of enrollments.)

In 1958, again the effort was made to establish a program for the training of teachers of mentally retarded children. We hired a specialist from the University of Illinois and gave him a reduced teaching load so that he would have time to develop a program in the training of special education teachers. During the summer session of 1958, there were 15 scholarships offered in an attempt to stimulate interest in special education. We brought in a specialist in methods to assist in the program. We had 17 people enrolled in the introductory course in special education and in the methods course for teaching the slow learner; 6 people enrolled in a course designed to improve methods of teaching the speech-handicapped.

In the summer of 1959, again with a visiting specialist - from California - in addition to the local staff and several scholarships, we had 13 people enrolled in the introductory course, 4 people in the seminar, 9 people in the special methods course, and 7 people in the methods course for the speech handicapped.

In the summer of 1960 in an attempt to build enrollment, we "borrowed" the special education staff member from the Woman's College campus, which was also offering courses in special education. We brought her to this campus so that we would be able to justify offering the courses. Last summer we had 22 people in the introductory course on teaching exceptional children, 10 people in a course on the gifted, 11 people in a methods course, and no one in the advanced seminar.

This presents somewhat of a sketchy picture. Certainly we have facilities. Last summer we used children in special education in the Chapel Hill School System and put them in our demonstration room in the new Peabody Building with their regular teacher. In the summer before, we used the Chapel Hill Schools for observation and demonstration. The Dean has difficulty justifying some courses to the administration. In fact, he cannot offer a graduate course with fewer than 5 students enrolled and has difficulty justifying even to himself and to other members of the administration a person who is employed and has an average teacher-pupil ratio of 1 to 10 or less.

Now, these are problems; the Dean says if we had the students, we could provide the program. But where are the students? We look at the requirements; someone raises the question, "How many classrooms in special education are without teachers?" The answer is, "No superintendents who have wanted to institute special education classes have not found teachers." But then the point is made that there would be more superintendents who would institute special education classes if they could get more teachers.

Others here are in a better position to comment on how many of the teachers that are currently teaching special education are actually qualified according to the requirements and how many are actually operating on a provisional or sub-standard certificate.

We know that there are some people who go into teaching special education partly because they have a certificate and want to teach in a particular location. Many of these people who have certificates would rather teach in the regular classroom than in a special education

classroom. In the first place, they are already certified to teach and don't need an additional 24 hours, and they feel that it is much more rewarding to work in a regular classroom.

We have some who have been certified, but for personal reasons they need to teach in a certain area; and the only way they can teach is to take a special education class. So, with some help, they come back and pick up 6 or 12 hours in the summer session to get a provisional certificate. We have other instances where Women's Clubs in certain communities have sponsored a teacher at a summer session in order to qualify her to teach a particular class.

Now, I do not know whether this five per cent bonus that Mr. Barker mentioned yesterday is the way to induce additional people into preparation for teaching in special education. I have a personal feeling about this. I am not convinced it is justified if we are getting people into special education because of the additional financial inducements rather than an interest in this type of child. On the other hand, if this five per cent can be looked at as an additional payment for the special preparation required, then certainly it would be justified.

As far as the situation in North Carolina is concerned, I am not sure what the answer is. I know that there are fractional programs; there has been a summer program at the University of North Carolina. There are programs at East Carolina, at Western Carolina, and at Appalachian. I do not know how complete these programs are. It may be that now is an opportune time for someone to take action. I am not letting out any secrets, but the special education teacher at Woman's College is leaving; I suspect her primary motivation for leaving is

that she prefers to teach courses in special education which she could do only during the summer session at Woman's College. She prefers to teach full time in special education. This is one problem which we have here on this campus. A person trained in special education must be fitted into a regular teacher training program in order to justify his place on the staff. Our specialist in special education is also moving at the end of this year.

If we could get the Board of Higher Education to outline some plan of coordinating a teacher preparation program in special education and locate, perhaps, a training program in speech therapy at one institution, perhaps a mentally retarded section at another institution, perhaps a gifted section at another institution, this may be an answer.

I have tried to explain the situation as it is here: partly students, partly staff. I am not sure which comes first. You cannot justify a program without students, and you cannot attract students without a program.

Thursday Afternoon Discussion - Shortage of time precluded thorough discussion. Salient points covered in the presentations were briefly reviewed.

The need to integrate problems of teaching the retarded child into undergraduate courses was considered as great or greater than the need to develop graduate training although this is important, too. Throughout the discussion it was repeatedly pointed out that special programs are needed less than the integration of the subject into existing course instruction. Professional groups deserve to have the opportunity to become more acquainted with mental retardation and all its social complexities.

As an example, in the school of social work the instructors cannot anticipate all the settings a social worker might possibly find himself. However, as a problem mental retardation and its social consequences give an excellent example of a well-studied sociologic issue worthy of consideration in courses in sociology and social work. This holds true in other fields as well.

All institutions of higher learning bear a heavy responsibility through their professional schools and through basic science departments to be active in research and training in mental retardation.

# SUMMARY OF CONFERENCE

1. Medical and educational resources are the major categories of need.

2. Provision of a setting which promotes maximum development of individual potential without encroaching on basic human rights is the ideal goal.

3. The community can provide for most of its problems with exceptional children both from the educational and medical standpoints.

4. Education and training of the exceptional child is basically the responsibility of the local school system and can be integrated into the overall provision of adequate schooling, recreational, and vocational opportunities.

5. Medical (including psycho-social) needs can come from the communities' medical resources by the development of diagnostic services in cooperation with family physicians and specialists in the areas of social work, psychology, nursing, pediatrics, and neuropsychiatry.

6. The residential centers are special centers (i.e., "communities") for the mentally retarded person who cannot adjust to or be helped in his own community for medical, psychological, or social reasons.

7. Residential centers must be geared toward rehabilitation, socialization, psychological adjustment and away from custodial care.

8. Certain cases will need residential supervision all their lives or during periods of stress. The movement in and out should be emotionally smooth.

9. Training of students in professional schools is a vital problem.

10. Departments in colleges and universities must recognize their responsibility to cover this subject in their curricula, both on undergraduate and graduate levels; this is particularly true of departments and schools of education.

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